



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Montana**

**Application for 2008
Annual Report for 2006**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The State of Montana maintains on file in its Fiscal Division all the assurance required by this application for Maternal and Child Health Block Grant. On file in agency rules are prohibitions of necessary items. The agency assures the MCHBG that the funds will be used for non-construction programs, that debarment and suspension remain in place as in previous years, that the agency is a drug free work place and tobacco free. The agency has on file all necessary paperwork for lobbying state legislature and the prevention of fraudulent use of fund.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Public input is solicited through local public health departments in the form of pre-contract surveys. Counties are also required to include consumer surveys in their contract responsibilities, to further inform them regarding the impact of MCH programs. Administrative Rules of Montana requires counties to conduct periodic needs assessments, which are reported via the pre-contract surveys.

Public input is also obtained from the Family and Community Health Bureau (FCHB) Advisory Council members, who represent various MCH partners and constituents. Updates on the needs assessment process were provided to the FCHB AC at each meeting during the last year, and the needs assessment and the priorities were sent to the AC for review and comment prior to finalizing. Advisory Council members will be invited to participate in the video link to the block grant review. A report on review findings is scheduled for August, and a copy of the final reviews are sent to the AC following receipt.

Copies of the block grant are made available to Advisory Council members, and availability of the text and data and updates on the block grant are provided through the FCHB Facts newsletter. The newsletter is distributed electronically every other month, and has a distribution of approximately 180 (in department) and 100 (out of department). A copy of a recent FCHB Facts newsletter is attached.

//2007/ The public input process is unchanged from 2006. A proposal has been made that the FCHB Advisory Council members be governor-appointed (attached). A link to the MCHBG application and narrative will be added to the FCHB website. //2007//

/2008/ The public input process remained similar to 2007. The FCHB Advisory Council continued to meet quarterly in 2007 and provided input on the August 2007 MCH BG Review and on the 2008 MCHBG application. The Governor's Office has replaced the FCHB Advisory Council with the Family Health Committee and it is anticipated that the Governor's appointments will be made in the Fall of 2007. The Governor announced the Family Health Committee Members on August 15, 2007. (attached) The local county health department's lead public health officials' provided input electronically on the state's creation of a new state performance measure. The MCHBG application and narrative are available at <http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml>. //2008// An attachment is included in this section.

II. Needs Assessment

In application year 2008, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The 2005 Needs Assessment was submitted with the 2007 MCH BG application. Technical assistance specific to the state's revision of the 2005 Needs Assessment process has been requested with the 2008 application. The Needs Assessment is an ongoing process and the results continue to be included in the Family and Community Health Bureau's Strategic Plan. The Bureau's Strategic Plan, which was based on the 5-year MCH Needs Assessment, was used by the Family and Community Health Bureau sections to develop section workplans. The workplans reflect the goals and objectives in the Bureau-wide plan, and also include activities or action steps for achieving the goals. Each section reviews and updates their work plan periodically. Additionally, the entire Bureau meets quarterly at which time the Strategic Plan is included on the agenda as a discussion item and potential updates or revisions are discussed.

III. State Overview

A. Overview

Montana's geography, population size and distribution, nature of her minority groups, political jurisdictions, and economic characteristics have a profound effect on: the health of her citizens; how direct and public health services are provided; and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives, and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and seven Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and state parks and state forests. The eastern two-thirds of the state is semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. The Insurance Institute for Highway Safety published a study of traffic safety laws in all 50 states in June 2005. The laws they rated were seat belt use, young driver licensing, DUI, child restraint use, motorcycle helmet use, and red light camera laws. Montana had the poorest ratings for motorcycle helmet use and red light camera laws, with only marginal ratings for young driver licensing, safety belt use, and child restraint use. Montana was the third highest state for motor vehicle deaths per 100,000 people in 2003, accounting for 262 deaths. For 2004, Montana ranked 50th in the nation for motor vehicle fatalities with 2.5 deaths per 100,000,000 miles driven.

POPULATION CHARACTERISTICS: U.S. Census reports the 2000 population was 902,195, 44th in terms of population, with a population density of 6.2 people per square mile. The 2004 population estimates for Montana suggest an overall increase of 2.7% from 2000, with the in-state population redistributing to the western portion of the state and into urban areas. Montana has three metropolitan areas and five areas with a population over 10,000 people. Sixty-four percent of Montanans reside in these eight areas, with the remainder of the population dispersed into smaller communities, farms, and ranches. In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2004. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Projected population for 2030 is 1,044,898, ranking 27th in the nation for population growth.

The median age in Montana for 2000 was 37.5 years, higher than the national average of 35.3 years. Projections for 2030 suggest Montana's median age will increase to 46.0 years, representing a 22.7% increase in median age for the state. Montanans over 62 years of age are predicted to increase 115.6% by the year 2030, with a 0.4% decrease in children less than 18 years of age. Montana's population is split evenly between males and females. In 2000, the median age for men was 36.6 and for women was 38.5. Women of reproductive age (15-44 years) comprised 20.5% of the state population, and children and youth under 20 represented 28.5% of the population.

In 2002-2003, Montana pupils scored at or above proficiency for math, science, and reading assessments. Montana ranked 28th in math proficiency and 9th in reading proficiency, according to CFED for 2004. Montanans also tested slightly higher than the national average on the ACT, with 81% of graduating seniors taking the test. For 2003-2004, Montana had a high school diploma rate of 82.9% and a high school completion rate of 84.8%. Historically, Montana's pupil teacher ratio has been significantly smaller at 14.5 pupils per teacher than the U.S. average

of 15.9. IEP percentages (learning disabilities) were slightly higher than the national average during the time interval. For 2003-2004, Montana ranked 47th in teacher salaries (\$37,184), and state budget allocations for education were significantly lower than the national average (12% difference). People in Montana 25 years old and over with a bachelor's degree or more in 2003 accounted for 24.9% of the population, ranking 27th in the nation. Estimates for 2004 suggest a 2.4% increase from 2003. Montana's university system comprises of two universities, four colleges, and five colleges of technology. In addition, there are six private colleges, seven tribal colleges, and three community colleges. Montana ranked 22nd in the nation for computer and internet presence in the home.

In 2002, Montana ranked 34th in total crime per 10,000, 29th in violent crimes, and 24th in the juvenile crime index. In 2002, Montana ranked 31st in percent of births to unwed mothers. There were approximately 13.6 TANF recipients per 1,000 population in April 2005, 87.7 food stamp recipients per 1,000 population, with the average amount of food stamps per household equal to \$215.44. Both the number of cases and the average amount per case has increased steadily since 2000, according to DPHHS.

Montana is predominately white with approximately 91% of the 2000 population reporting Caucasian as the primary race, compared to 75% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.2% of the total population (56,068), the 5th highest state in the nation. Estimates for 2003 suggest a 4.8% increase from 2000, with American Indian births accounting for approximately 12.2% of the births in the state. The number of people of Hispanic origin has been growing faster than other minority groups with the exception of Native Americans, demonstrating a 5% increase from 2000 to 2003 (estimate). Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites. There are also isolated pockets of other minority groups including a Southeast Asian cluster of about 200 to 300 persons in western Montana as well as about 300 Russians.

2000 Census Population Demographics

| | | | |
|-----------------|-------|-------|------|
| White | 90.6% | Asian | 0.5% |
| American Indian | 6.2% | Black | 0.1% |
| Hispanic | 2.0% | Other | 0.7% |

ECONOMIC CHARACTERISTICS: Montana's economic history is one of extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues. However, these extraction processes have left a legacy of environmental pollution. In 2004-2005, Montana had 15 Federal Super Fund sites and 208 CERCA priority facilities. The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana DPHHS has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the EPA in 2005, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. DPHHS Environmental Public Health Tracking was established in 2004 with support from a 3-year grant from the CDC. EPHT's vision is to better protect communities from adverse health effects through the integration of public health and environmental information, such as the Libby, Montana exposure. EPHT will improve surveillance of chronic diseases, birth defects, and developmental delays, and link health data with existing data on environmental hazards and exposures, to better inform the public regarding health concerns.

Montana also ranked 50th for employment wages, with the average annual pay equal to \$26,001 for 2002 and 2003 estimates increasing only 3.3%. In 2001, at least 9.3% of employed individuals in Montana held more than one job. In December, 2004, the top five employment industries in the state were government, trade, transportation and utilities, education and health

services, leisure and hospitality, and professional and business services. Tourism is becoming a major industry -- non-state residents spent \$2.7 billion in the state in 2002. Approximately 9.8 million visitors generated 43,300 Montana jobs. However, tourism jobs are typically in the service sector, which pays relatively low wages for the majority of jobs.

Federal aid to state and local governments per capita for 2003 ranked Montana 12th in the nation. Federal funds accounted for 62 cents of every dollar of state revenues spent. Resources supporting state level efforts for MCH and CSHCN are overwhelmingly federal -- less than 5% of funding for the FCH Bureau or the CSHS section is from the state general fund. Montana depends on its local partners to make up the required match for the MCHBG. Data for 2002 suggests Montana had \$6,973,894 in federal funds and grants.

POVERTY: Montana is ranked 11th in the country for percent of the population below poverty level for 2000-2002. According to 2002 Census estimates, 25.5% of children under five and 16.7% of children ages five to 17 live in poverty. Overall, 14.0% of Montana's population lives in poverty, while the national average for 2000-2002 was 11.7%. Preliminary 2003-2004 data suggests Montana has 20.2% of it's children living in poverty, ranking the state 42nd in the nation. Five out of seven reservations are found in eastern Montana, an area with limited natural resources, high unemployment, and disproportionate poverty. Since 2001, Montana's unemployment rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2004 was 4.4%, compared to the U.S. rate of 5.5%. However, unemployment for the tribes ranged from 40.58% to 77.21%, with an average unemployment rate of 59.63% for 2001 Montana Progressive Labor Caucus data. Reservation data collected by Montana DLI suggests lower unemployment rates may exist. Year after year, data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

Annual Average Unemployment Rates on Montana's Reservations

| Reservations | 2001 | % Employed but below poverty | Tribes 2001 |
|--------------------|--------|---------------------------------|-------------|
| Blackfeet | 70.0% | 26.0% | 69.93% |
| Crow | 66.0% | 16.0% | 60.65% |
| Flathead | 76.0% | 22.0% | 40.58% |
| Fort Belknap | 71.0% | 20.0% | 70.49% |
| Fort Peck | 63.0% | 23.0% | 62.54% |
| Northern Cheyenne | 27.0% | 7.0% | 64.69% |
| Rocky Boy's | 36.0% | 37.0% | 77.21% |
| Reservations Total | 59.86% | NA | 59.63% |

In 2004, Montana ranked 20th in bankruptcy filings by individuals and businesses. Homeownership rates for 2004 data suggest 71.5% of Montanans own their home, ranking 23rd in the nation.

POLITICAL JURISDICTIONS: The state has 46 frontier counties, 8 rural counties, and only 2 urban counties. Fifty-four county health departments contract with the DPHHS to provide MCH and other health services, but the local health departments are county entities under the control of local Boards of Health, and the staff are county employees. The seven Indian reservations have nation status for 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems. The other three tribal health clinics belong to the three "compact" tribes that staff their own clinics. Although the I.H.S. data system is used at all seven tribal health clinics, patient health data that is not entered into the system for I.H.S. staff services may not be shared with the State without separate agreements with the three compact tribes. According to the Tax Foundation, the federal tax burden on Montana is 17.5% for 2005, ranking Montana 35th in the

nation. The state and local tax burden is 9.5% for 2005, ranking the state 39th in the nation. New tax relief measures implemented in 2005, including a 10% tax bracket, child tax credits, reduction of income tax rates, and reduction of the marriage penalty, will provide benefits to thousands of taxpayers and businesses. Child tax credits, reduction of income tax rates, reduction of the marriage penalty, and other changes to the tax laws will benefit many Montanans.

ACCESS TO HEALTH CARE: Nine counties have no private medical services at all. There are 54 local county public health departments. Health care for the tribal residents of Montana is provided by a network of services including: off-reservation hospitals; clinics and practitioners; county health departments; Indian Health Service systems; and tribal health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte. Montana ranked 15th in the nation for the percent of health dollars for public health, 19th in per capita public health spending, and 36th in adequacy of prenatal care. Montana has 21 local hospitals, 40 Critical Access Hospitals (CAHs), and 20 Community Health Centers. All hospitals provide access to care for low-income, indigent, Medicaid, and Medicare patients. There are two hospitals that provide pediatric mental health care, five provide care exclusively for veterans and American Indians and are federally owned and operated. All but the hospitals in Billings and Great Falls are classified as rural facilities by HCFA. Sixty percent of primary care physicians are located in Silver Bow, Yellowstone, Missoula, Gallatin, Cascade, Lewis and Clark, and Flathead counties, the seven most populated counties in Montana. Establishment of Rural Health Clinics (RHC), under the provisions of PL. 95-210, has improved access to health care in many counties and communities. There are 40 Rural Health Clinics in Montana and several additional sites are currently considering conversion/establishment of a RHC. There is one Migrant Health Center (MHC) in Montana located administratively in Billings. Satellite services have been provided over the last several years in six locations.

According to 2004 CFES data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums.

Oral health care had become a major public health issue. The Montana Foundation of Dentistry for the Handicapped provides free comprehensive dental care to people who are permanently disabled, medically compromised or elderly, and who cannot afford dental care. Six Montana Community Health Centers (Billings, Butte, Great Falls, Helena, Missoula and Libby) include some dental services, though the waiting lists can be long. Dental clinics are offered in thirteen locations through the Indian Health Service. Montana's point-in-time PRAMS in 2002 reiterated lack of access to dental care for pregnant Medicaid participants was a statewide problem. Data for 2004 suggests Medicaid-payable dentists are also a resource problem, with 14 counties lacking at least one Medicaid-payable dentist and 14 counties with only one Medicaid-payable dentist, representing 50% of all Montana counties. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

High mortality rates are a large problem for Montana. Montana ranks 46th in the nation for occupational fatalities, with 12.3 deaths per 100,000 workers for 2004. Cardiovascular deaths for 2004 equaled 296.2 per 100,000 people, ranking 11th in the nation. Cancer deaths in Montana

ranked 23rd in the nation, infant mortality 27th in the nation, premature death 22nd in the nation, and total mortality 32nd in the nation. Leading causes of death in Montana are heart disease, cancer, cardiovascular disease, diabetes, pneumonia, chronic obstructive pulmonary disease, and accidental deaths due to unintentional injuries. For Montana Indians, accidents, diabetes, and chronic liver disease and cirrhosis follow heart disease and cancer for the leading causes of death. Whites typically die at an older age than Indians. (Montana Bureau of Records and Statistics, 2003) Montana is 2nd in the nation for death rate by suicide, at 19.3 per 100,000 population in 2001.

Drug abuse in Montana is a growing concern, especially methamphetamine use. The U.S. Drug Enforcement Administration reported 2003 federal drug seizures in Montana included 0.5 kg cocaine, 107.2 marijuana, and 8.8 kg of methamphetamine. In 2002, Montana law enforcement agencies responded to 122 meth labs statewide. BRFSS for 2003 reported 9.3% of students grades nine to 12 reported using meth at least once in their lives. The Billings area has an active methamphetamine task force while other communities scramble to become informed about the implications of meth use and the potential impact on the maternal and child populations in their areas.

Domestic violence continues to grow in scope. Statistics for 2001 suggest 7.0% of aggravated assaults were by a spouse or ex-spouse and 6.5% were from boyfriends or girlfriends. PRAMS data for 2002 suggests 8.8% of all Montana women aged 15-45 are abused before pregnancy and 5.0% during pregnancy. However, the Montana Board of Crime Control suggests reported domestic violence to be only 0.45% of the population-at-risk for abuse, suggesting underreporting is a serious issue in Montana.

CDC's State Health Profile for Montana notes childhood health concerns include birth defects, vaccination coverage, infant mortality, prenatal care, and teen pregnancy. Montana has developed a birth defects registry that now contains data for 2000 through 2004. A heightened rate of Down's Syndrome appears in the data, along with other defects of concern including gastroschisis, diaphragmatic hernia, and cardiovascular defects. The Fetal Infant Child Mortality Review (FICMR) program, authorized by the Montana State Legislature in 1997, has published two reports since its inception. There were 1,256 fetal, infant, and child deaths in Montana from 1997-2002, accounting for 1.0% of the cumulative birth cohort (N=130,694). Cumulative review percentages suggest 59.2% of all fetal, infant, and child deaths were reviewed by the 27 local FICMR teams covering 48% of the counties. Nevertheless, the program determined that 39.7% of the cumulative reviewed deaths that contained prevention findings were preventable.

Montana continues to face a health care worker shortage. During the reporting years 2001 to 2002, a task force was created and appointed by the Governor "to accurately assess the shortage of health care workers, and to develop recommendations and strategies to effectively address the issue." As of 2002, there were 2.0 physicians per 1,000 population, as compared to the U.S. average of 2.3 physicians per 1,000 population, according to the Northwest Area Foundation. This statistic ranks Montana approximately 34th in the nation. For the year 2012, DLI predicts only 2,077 physicians and surgeons for Montana, a rate of 2.1 physicians per 100,000 population, based on a 984,043 population projection. Dieticians and nutritionists are projected to reach 216, a rate of 2.2 per 100,000 population. Registered nurses are projected to reach 10,707, a rate of 10.9 per 10,000 population. However, even with all the known shortages, Montana's response has only been to establish a task force commission or panel, which is 1 out of 7 measurable responses.

In 2002, Montana ranked 44th and 47th in the nation for series of immunizations given to 19-35 month old children. In 2003, Montana ranked 24th in infant mortality at 6.8/1000 live births. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. In 2002, Montana estimates indicated 54% of the adult population to be overweight or obese. The same dataset estimated the adult smoking prevalence rate to be 19.9% of the population. Smoking-attributable direct medical expenditures (state share) are estimated at \$216

million. There are approximately 1,439 annual smoking-attributable deaths in Montana, according to the Center for Tobacco Cessation. Montana is 1st in the nation for adolescent male use of smokeless tobacco. In 2000, Montana ranked 35th in Medicaid recipients and 25th in state and local funding spent on health and hospitals. Montana ranked 34th in per capita spending on Medicaid recipients, 7th in average Medicaid spending per child, and 19th in Medicaid spending on aged recipients. Montana ranked 6th in the nation for hospital expenses per inpatient day at \$2,573. In 2003, Montana had 47,088 enrollees in HMOs in 2003, down from 2002.

This snapshot does not tell the whole story. Montana needs nearly 1,000 more health care workers right now just to catch up to the national averages! And, as Montana's population continues to age, demand for all occupations - including those that are now adequately staffed - will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of our older-than-average population

/2007/

POPULATION CHARACTERISTICS: The 2005 population estimate for Montana is 935,670, constituting a 3.7 increase from April 2000 to July 2005
<http://www.census.gov/hhes/www/poverty/poverty04/stategrid.xls> .

POVERTY: Census figures for 2002-2004 indicate the percent of Montana's population living in poverty is up to 14.3% <http://www.census.gov/hhes/www/poverty/poverty04/stategrid.xls>

ACCESS TO HEALTH CARE: Montana has eleven Community Health Centers, with seven satellite sites, one Migrant Health Center with nine satellite sites, and one Healthcare for the Homeless Program with three satellite sites. Four additional communities have submitted Community Health Center applications. Oral health services are available at eight of the centers and through two mobile clinics. <http://www.mtpca.org/mtcenters.htm> //2007//

/2008/ POPULATION CHARACTERISTICS: The 2006 population estimate for Montana is 944,632 constituting a 4.7 increase from April 2000 to July 2006. Population growth continues to be primarily in and around communities that are already the most urban in the state. Two exceptions are Flathead and Ravalli Counties, where population growth may be producing two new "urban" areas.. The majority of population growth since 2000 has been in counties in western and south-central Montana. The Montana Census and Economic Information Center at the Department of Commerce projects that the state population will continue to grow at similar rates for the next few years. (http://ceic.mt.gov/Publications/Newsletter_Fall_Winter_06_07_Final.pdf)

The increases cannot be attributed to increased birth rates, which dropped to an all time low (for the last 100 years) to 12.1 from 2000 to 2002, increasing slightly back up to 12.4 for 2003 -- 2005. <http://www.dphhs.mt.gov/statisticalinformation/vitalstats/2005report/2005selectedeventsrates.pdf>

54 of Montana's 56 local city/county health departments providing maternal and child health services to their residents are contractually required to establish a memorandum of understanding regarding coordination of services with Indian reservations, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. The local city/county health departments are contractually required to establish a memorandum of understanding regarding coordination of services with Indian Health or Tribal Health Services, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. Several MCH programs, i.e. Public Health Home

Visiting, Cleft Palate Outreach Clinics, are operating on several reservations with a goal for 2008 to increase the number of partnering reservations.

POVERTY: Census figures for 2003-2005 indicate the percent of Montana's population living in poverty is up to 14.4%

<http://www.census.gov/hhes/www/poverty/poverty05/table8.html>

ACCESS TO HEALTH CARE: Montana has thirteen Community Health Centers, with seven satellite sites, as well as a Migrant Health Center that provides services statewide and one Healthcare for the Homeless Program. Additional sites continue to be under development for CHC status. Efforts to help develop the oral health services available at most of the sites are underway in the state, supported by Temporary Assistance for Needy Families funding awarded to the state. Further expansion of oral health services has also been proposed in the Targeted State MCH Oral Health Service Systems Grant Program submitted July 2007. //2008//

An attachment is included in this section.

B. Agency Capacity

The Title V programs are located within the Health Resources and Public Health and Safety Divisions of the Department of Public Health and Human Services. The structure of DPHHS is described in the organizational structure section of this application. Title V efforts are primarily focused in the Family and Community Health Bureau of the Public Health and Safety Division (PHSD) and in the Children's Special Health Services (CSHS) program, which is located in the Health Care Resources Bureau of the Health Resource Division.

The Family and Community Health Bureau (FCHB) is the primary MCH agency, responsible for development of the MCHBG report and plan, budget monitoring, and implementation of the plan. The Family and Community Health Bureau has a staff of approximately 30, and a budget of approximately \$21 million, from 13 funding sources including grants from CDC, HRSA, SAMHSA, USDA, the Office of Population Affairs, and Montana general fund. The largest program and budget is the WIC Program, with a budget of approximately \$14 million. The MCHBG is the second largest funding source, at about \$2.5 million annually. Approximately 95% of the FCHB budget is federal dollars.

Local providers are crucial partners in the provision of MCH services in Montana. Approximately 42% of the MCHBG is contracted out to local health departments to provide MCH services to the population. Of the \$1.1 million of state level match, 1/2 of that is also contracted to local health departments for public health home visiting services to pregnant women and infants. The remaining \$500,000+ is contracted to for genetics services for the MCH population.

FCHB is also responsible for coordinating the MCH needs assessment and subsequent further prioritization of MCH needs and strategic planning that will take place in 2005 and 2006.

The Children's Special Health Services (CSHS) program in the Health Care Resources Bureau administers 30% of the MCHBG. HCRB provides services to children in three ways: direct services to children, indirect services to children, and administrative services.

Direct services to children include cleft cranio-facial clinics, metabolic clinics and case management services, regional clinics, nutrition services, neonatal follow-up, newborn screening follow-up, medical home program, transition services, case management, care coordination, clinic coordination, systems of care development, dental services, vision services, hearing aids, medical services, enrollment, and medical reviews.

Indirect services to children include: outreach, cultural competence, plan relations, provider

relations, advocate liaison, enrollee education/newsletter, quality assurance/improvement, customer service, family support and referral, health care integration for access, coordination and referral, policy development and review, complaint processes, web page development and maintenance, and data systems development and coordination.

Administrative services include: office and facilities management, personnel management, labor-management relations, state/federal coordination, CHIP State Plan, MCH Block Grant submission, administrative rules, file and chart systems, research, professional development, surveys, technical assistance, contracts, waivers, payroll, new employee orientation, communication, budget and fiscal, performance measurement, grant writing, safety and security, program evaluation, legislative support, congressional requests, public relations, and purchasing and inventory.

Co-location of the CSHCN program with the CHIP program has facilitated coordination of applications for services for children between those two programs, Medicaid, and other programs, which may benefit children and their families. The HCRB Bureau manages the Family Health Line, which is the Title V toll free line, directing callers to programs within DPHHS and around the state. The Children's Mental Health Bureau is also located in the HR Division. That bureau is directing development of the Kid's Mental Health Services Areas or KMA's in the state, which may address and improve the mental health service needs of the MCH population. Services are provided to Montana children with special health care needs and their families by the CSHS program staff and their contractors.

Services include specialty clinic services, direct payment of medical services for eligible children who have no source of payment for needed care, identification and referral of children with special health care needs, and consultation and technical assistance. The number of children receiving direct pay services has decreased as insurance coverage becomes more available. In Montana, CSHCN program eligibility is based on diagnosis/condition and financial eligibility. Montana does not have a medical school or a school of public health, and relies on partnerships with private providers to develop and deliver services to the vulnerable populations. The CSHS has developed partnerships with two hospitals in Missoula and Billings for regional specialty clinic services, and is working towards development of a third regional clinic site in Great Falls. The Montana Legislature included a line item to support additional regional clinic development in the 2005 session. Program staff is developing the ability of clinics to bill for services, which will diversify funding available to support these sites, which have been primarily supported by hospital in-kind and MCHBG contract funds to date.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Parents Lets Unite for Kids (PLUK) is a longstanding advocate for parents and families, and the host organization for Montana's Family Voices chapter. Work with PLUK has centered on collaboration to improve access to community-based, family-centered services for CSHCN.

The Family and Community Health Bureau's mission is the "promote the health and well being of Montana's citizens to help healthy families build health communities." The bureau is organized into four sections: the MCH Data Monitoring (MCHDM) section, the Child, Adolescent and Community Health (CACH) Section, the Nutrition/WIC Section and the Women's and Men's Health Section. MCHBG funding and program efforts are primarily located in the MCHDM and CACH sections.

The MCHDM section manages the 54 local MCH services contracts, oversees the MCH block grant development and performance measure monitoring, and is responsible for the population based newborn metabolic and hearing screening programs. That section has also housed the Point in Time Pregnancy Risk Assessment Monitoring project from 2001 -- 2004; the state intends to apply for CDC funding to reinstate the program in 2005. The MCHDM section also manages the state's genetics program and contract, which is funded with a tax on individual insurance policies. Legislative changes in 2005 resulted in an increase of that funding source, which will in

turn result in a reassessment of contractor role and services.

The MCHDM section houses Montana's birth defects registry, the Montana Birth Outcome Monitoring System (MBOMS), which was initiated with CDC funding in 2000. The population-based registry identifies and refers children in need of services to the CSHCN and other appropriate services. Initially, the program was a passive case ascertainment system, focusing on four major anomalies - congenital hypothyroidism and cleft-craniofacial, cardiac, and neural tube defects. CDC recommended active case ascertainment, which was added in 2001. The program was funded for an additional three years of CDC funding in 2002. A renewal application submitted in early 2005 was reviewed, approved, but not funded, leaving the future of the registry in question. At present, the registry, including the active case ascertainment will be continued with carry over dollars, supplemented as possible with MCHBG. The long-range feasibility of continuing this support continues to be in question, especially in view of the MCHBG decreases over the last several years. Birth defect monitoring efforts continue with grant carryover and MCHBG funding at this time -- partnerships with the state's Environmental Public Health Tracking program are being explored. The registry has helped identify and inform investigations of what appeared to be high instances of Down Syndrome and gastroschisis in Montana over the last several years. The gastroschisis investigation continues with the help of student efforts from the Rollins School of Public Health at Emory University.

Montana's "heelstick" newborn screening follow up has been housed in the FCHB since 1995 and is a part of the MCHDM section. Follow up efforts continue to be a partnership between medical providers and hospitals, the public health laboratory, parents, the FCHB and the CSHCN program. Montana presently screens for four department-required blood tests for PKU, galactosemia, congenital hypothyroidism, and hemoglobinopathies. Interest in adding additional tests has been expressed by the medical community, but in light of fiscal constraints and resistance to increases in existing lab charges, no additional lab screenings have been mandated in the last few years. Montana is monitoring national efforts to recommend additional screening tests in the future. At present, our state lab, which conducts newborn screening for the state, lacks mass spectrometry equipment, which will be necessary for inclusion of some of the additional tests. The lab presently works with out of state labs to facilitate provider requests for additional testing.

Newborn hearing screening is also coordinated by the MCHDM section, in conjunction with the metabolic screening program and the birth defect registry. Montana has increased capacity for newborn hearing screening in the state, moving from approximately 30% of newborns tests 4 years ago to more than 80% at present. The state and the advisory group for this program now face the difficult task of how to facilitate screening in the very small communities where limited resources for testing and follow up exist, and to assure effective follow up, especially in small communities. The group will be examining various approaches to this challenge in FFY 2006.

The MCHDM has been the lead player in development of standardized reporting capacity for local public health, concentrating on MCHBG and PHHV reporting requirements. The Integrated Data for Evaluation and Assessment (IDEA) Project was designed in 1998 to provide improved support for the delivery of maternal and child health-related services at the state's local public health departments and to improve local and state capability for evaluation of program effectiveness. The Public Health Data System (PHDS) was developed for use at local health departments to support their client case management and reporting capability. PHDS has been designed to support four of the public health programs provided at the local level -- client case management and tracking, an initiative to serve women with high risk pregnancies, family planning and immunizations. The immunization component will include: population of the immunization registry with birth record data; immunization data from the Indian Health Service and participating tribal health departments; and linkage with private providers of immunizations. Interface of the PHDS with the Indian Health Service data system in use in Montana's tribal health department stalled when the IHS decided to establish its own national immunization registry interface protocol for use by all states. The PHDS has been rolled out to 83% of the local public health departments,

and plans to convert the web based structure with increased ease of data entry is presently in process.

In 1985, the Montana legislature authorized the creation of a voluntary statewide genetics program, funded by a tax on individual insurance policies. The program provides for newborn heelstick screening follow up, and genetic services and education for the people of Montana. FCHB provides the newborn screening program follow up, referring children identified with metabolic disorders to the CSHCN and genetics programs for intervention and evaluation. In 2004, a formal request for proposal (RFP) process was undertaken to award a new contract for clinical genetic services for Montana after more than a decade of annual renewal of the existing contract. A new contract has been awarded to the previous contractor and services and reporting requirements have become more clearly focused. The 2005 Legislature considered and passed a bill increasing the tax on individual insurances, which provides the funding to support the program. This increase sunsets in 2007, requiring the department to investigate alternative mechanism to fund the programs, with a goal of increasing the base upon which the funding depends.

The Child, Adolescent and Community Health Section houses many of the staff and programs most directly impacting the MCH population. Staff in the section manage and monitor the public health home visiting program for pregnant women and infants, the fetal infant child mortality review, the SIDS prevention, fetal alcohol prevention and youth suicide prevention programs, the early childhood comprehensive systems project, the oral health program, and provides consultation on general child, school and adolescent health issues.

The public health home visiting (PHHV) program has a long history in the state. In 1989, the Montana Legislature enacted legislation establishing the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) and supporting it with general funds. The goals of the legislation compliment the charges in Title V of the Social Security Act, which are to 1) assure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services, 2) reduce the incidence of infant mortality and the number of low birth weight babies and 3) to prevent of the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care. The program has continued to evolve, with efforts in 2004 targeting focusing the program on pregnant women and infants, and emphasizing home visiting as the preferred mechanism of providing services. At present, there are 19 contractors for PHHV services, including three tribal programs.

Montana's oral health program is also located in the CACH Section. The oral health program focuses on population based and infrastructure services to develop community awareness of the importance of oral health and to build capacity at the state and community levels. The program has benefited from the State Oral Health Collaborative Systems grant program, which has facilitated focus on system development. The oral health program coordinator has worked with the Primary Care Office and Primary Care Association over the last several years to focus education and cooperation regarding the importance of oral health and the serious access issues that exist in our state. The oral health program also coordinates school-based efforts to enable schools to conduct dental screening and fluoride rinse programs, and works in conjunction with the WIC, Head Start, Healthy Child Care Montana and the Child, Adult Care Food Program to develop appropriate services for the pre-school population. Training materials for public health and dental professionals were supplied to dental screeners and data recorders on a case-by-case basis to assure standardization and utilization of the Basic Screening Survey (BSS) surveillance instrument developed by the Association of State and Territorial Dental Directors (ASTDD).

The CACH section also supports efforts to prevent Fetal Alcohol Syndrome and Effect through prenatal prevention efforts. This effort was first supported by Congressional set-aside funding focusing on South Dakota, North Dakota, Minnesota and Montana. The project funded \$3 million dollars per year to develop a three component effort which included 1) the creation of a Four State FAS Consortium, charged with program development, implementation and evaluation, 2)

assessment which included gathering of consistent data with which to accurately assess the incidence and impact of FAS in the region and 3) intervention projects, focused on the prevention of fetal alcohol syndrome and fetal alcohol effect. Montana's intervention was built upon the PHHV/ MIAMI project, adding intensive home visiting and case management for pregnant women at risk of having a child with FAS/FAE. The project also enabled collaborative efforts to support FAS evaluation clinics in the state. Funding for the four-state consortium was no longer earmarked in 2004, and the staff applied for and received a Fetal Alcohol Syndrome Centers for Excellence award from SAMHSA in 2004.

The Fetal Infant and Child Mortality Review (FICMR) program directs and guides local efforts to review deaths of fetuses, infants and children 18 years of age or younger. The purpose of the review is to enable communities to identify risks or challenges in their communities and to implement appropriate prevention measures. State level functions are to compile and examine data looking for patterns and clues indicating statewide and/or legislative policy changes required. Examples of the uses of FICMR data include testimony to the 2005 Montana legislature regarding the importance and need for a graduated driver's license for young drivers, primary seat belt laws for children, and standardized medication administration policy in day care settings. The data was lauded by MCH advocates as useful and supportive of preventive efforts for the MCH population.

SIDS prevention is an ongoing effort in Montana, as in other states. A recent innovation has been the availability of a "Safe Sleep" program, providing safe cribs to needy families across the state. Public Health Nurses in counties and tribal settings may request cribs on behalf of clients who require a safe sleep environment for an infant. Requests for cribs are processed through public health nurses, and the cribs are then ordered and delivered to the public health nurse for delivery to the client. The added benefit of PHN contact and education regarding a safe sleep environment and other preventive information has been a major selling point for the program. Support for the program has been received by the Montana Healthy Mothers, Healthy Babies Coalition, private foundations and the Emergency Medical Services for Children Program.

CACH also provides technical assistance and consultation to local public health and school staff on matters impacting child, adolescent and school health. Efforts to continue general support and development of preventive and supportive Adolescent Health Efforts to develop strong adolescent health services continue with emphasis on the two top causes of morbidity and mortality in Montana: unintentional injury and suicide.

Suicide has, and continues to be recognized in Montana as a major public health concern. The department worked in conjunction with mental health provider, advocates, local partners and others to develop the first Suicide Prevention Plan, which was finalized in 2001. Funding was also obtained from the Governor's office in 2004, and from Preventive Health Block Grant carryover in 2005 to conduct an assessment of resources for suicide prevention in the state, and to support local efforts to prevent youth suicide. A report of the status of effort is attached to this document. DPHHS partnered with others to submit an application for a SAMHSA Cooperative Agreement to address youth suicide in June of 2005.

The Family Planning program receives a small amount (\$25,000) of MCHBG funding which it includes in the contracts with 15 local agencies to provide family planning services in 38 locations. Family planning programs are designated STD programs and all programs have enrolled medical service providers that provide comprehensive breast and cervical screening services to an identified target population. The family planning program serves approximately 28,000 men and women annually, including adolescents. The program helps to decrease the incidence of unintended pregnancies and births to teen mothers, which are MCHBG performance measures.

Statutory Authority for Maternal and Child Health Services Authority for maternal and child health activities within the Department are found in the Montana Codes Annotated (MCA 50-1-2020).

General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); accept and expend federal funds available for public health services, and use local health department personnel to assist in the administration of laws relating to public health.

Rules implementing the above authority are found in Title 16, Chapter 24, and sections 901 through 1001 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including crippled children, family planning and school health. A 1996 addition to the Rules describes the Standards for Receipt of Funds for Maternal and Child Health Block Grant. Newborn screening is required through ARM 16.24.201 through 215. MCH 50-19-301 through 323 authorized and describes the MIAMI project. Administrative rules describing and authorizing case management for high-risk pregnant women are contained in ARM 46.12.1901 through 1925.

/2007/ The Family and Community Health Bureau continues to be the agency within the Montana Department of Public Health and Human Services primarily responsible for services for the maternal child health population. The Bureau has reorganized over the last year. Children's Special Health Services, which is Montana's program for children with special health care needs, has rejoined the bureau and public health division. Major changes in program organization and responsibilities are highlighted here:

Child, Adolescent and Community Health (CACH): This section continues to be responsible for programs and services targeting the childbearing and childrearing populations, offering supportive programs in partnership with local agencies. CACH supports and promotes the Public Health Home Visiting (PHHV) program, which is part of the Montana's Initiative for the Abatement of Mortality in Infants legislation, which was passed in 1989. The initiative included community based efforts to work with high risk pregnant women and infants. The programs provides funding and training to 19 communities, including three tribal programs. The section also supports targeted efforts to identify and support families at risk for Fetal Alcohol Spectrum Disorder, by enhancing the PHHV with the addition of staff able to provide intensive home visiting services for these families. CACH was awarded a Garrett Lee Smith Memorial Grant in 2005, continuing and greatly expanding efforts to develop youth suicide prevention programs in communities across the state. The section is responsible for the Fetal Infant Child Mortality Review and for SIDS prevention efforts in the state. Staff includes the school health and adolescent health consultants.

Children's Special Health Services (CSHS): This section is responsible for system development and service support for children with special health care needs and their families. This section rejoined the bureau on January 1, 2006, and is responsible for regional speciality clinic development, family support enhancement (in conjunction with the state's Family Voices), and limited direct pay for services. The program works closely with clinic sites and with other programs serving CSHCN and their families, including Part C and the Montana School for the Deaf and Blind. The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking.

Maternal and Child Health Data Monitoring: This section is responsible for development and monitoring of the Maternal and Child Health Block Grant. The section has contracts with 54 of Montana's 56 counties, distributing approximately 42% of the MCHBG award locally to support MCH services identified by and monitored through ongoing community needs assessments. The section also supports abstinence education programs with Abstinence Education funding, and is responsible for the Oral Health Program, which was moved from the CACH section.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC): The

WIC/Nutrition Section administers the WIC program in Montana, which offers services through 29 contracts statewide and on in all reservation communities. The section also supports a Farmer's Market Program for WIC clients in select communities.

Women's and Men's Health: This section is primarily responsible for reproductive health services through Title X supported clinics across the state. The section monitors and supports community based efforts to prevent teen and other unintended pregnancies.

The Bureau staff and Advisory Council has developed a strategic plan based upon the information obtained through the MCH Needs Assessment in 2005. Priority needs were established and section activities developed in response to those needs.

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed.
//2007//

/2008/

The Family and Community Health Bureau, Montana's Title V Agency, continues with the basic structure of five sections as described in the 2007 update. The Abstinence Education grant was housed and funding distributed to local partners through the Maternal Child Health Data Monitoring (MCHDM) section. Montana, along with most states, received notification of the need to increase efforts to monitor and verify compliance with grant component in late 2006. After careful analysis, staff within the MCHDM section and FCH Bureau determined that the requirements were burdensome and would require that we decrease local funding in order to support the state infrastructure necessary to comply with requirements. With the support of the Department Director and staff from the Governor's office, Montana notified the Administration of Children and Families in January, 2007, of their intent to not accept Abstinence Education Funding beginning with the 2007 FFY.

The Early Childhood Comprehensive Systems grant, which had been housed in the Child, Adolescent and Community Health Section was moved to MCHDM in the spring of 2007. The MCHDM has also submitted a competitive application for the new Targeted State MCH Oral Health Service Systems Grant Program.

Two "units" consisting of focused responsibilities with staffs of two or less have been created during the last year. The first is the MCH Epidemiology Unit, responsible for overseeing the State System Development Initiative (SSDI) grant and advising on and conducting epidemiological analyses and evaluation projects across the bureau. We were very pleased to hire the Public Health Prevention Specialist assigned to Montana 2003 -- 2006 as our first epidemiologist, and are presently recruiting a second to join the Epi Unit.

The Primary Care Office is the second unit structure within the Bureau. The Primary Care Offices' responsibilities focus on facilitating federal designation of health professional shortage areas, and of supporting recruitment efforts for primary care, oral health and mental health professionals. This section was previously located elsewhere in the division, and compliments the efforts of the Bureau staff to promote and support access to quality health care for the MCH population in the state.

The Governor's Office continues to identify Council members to be appointed to the Family Health Committee, which replaces the Family and Community Health Advisory Council. The Governor's Office announced the new and continuing members on the Council on August 15, 2008.

The Bureau continues to encourage and support staff development through internal and external training opportunities. In the past year, staff attended cultural competency and diversity trainings, as well as Communication and Team Building Skills. Additionally, the Public Health and Safety Division has provided leadership training to all management staff and is providing communication training to all division staff in September 2007. An outgrowth of the managerial training was the creation of the Employee Feedback Group, composed of a representative from each of the five FCHB's sections that meets quarterly and provides feedback to the Division on the effectiveness of the managerial specific trainings. As of September 2007, the Family Health Council has been appointed by the Governor, and the first meeting has been scheduled for the end of October 2007. //2008//

C. Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director, Robert Wynia, MD oversees the agency, its 3,000 employees and approximately 2,500 contracts and 350 major programs. DPHHS has a biennial budget of about \$2 billion.

The Department of Public Health and Human Services (DPHHS) is a "mega agency" encompassing health and human services for the state of Montana. Statewide reorganization of health and human services agencies in 1995 created DPHHS by combining the Department of Social and Rehabilitation Services, the Department of Family Services, and parts of the Department of Health and Environmental Services and the Department of Corrections. During the reorganization, the environmental component of public health was separated and those functions now are carried out by the Department of Environmental Quality.

The reorganization combined public health and Medicaid services into a single division, known as the Health Policy and Services Division. In 2003, that division was split to create the Health Resources Division and Public Health and Safety Division.

The DPHHS Director's Office includes staff and programs that support the attainment of the department goals and the divisions' efforts to implement programs. The department has one deputy director, John Chappius, who also functions as the state Medicaid director. Programs within the director's office are; the Prevention Resource Center; the Office of Planning, Coordination, and Analysis; the Office of Legal Affairs; the Human Resources Office; and the Public Information Office. The Department's four broad goals are:

All Montana children are healthy, safe and in permanent loving homes.
All Montanans have the tools and support to be as self-sufficient as possible.
All Montanans are injury free, healthy and have access to quality health care.
All Montanans can contribute to the above through community service.

DPHHS is organized into eleven divisions. They are:

Addictive and Mental Disorders Division;
Child and Family Services Division;
Child Support Enforcement Division;
Disability Services Division;
Fiscal Services Division ;
Health Resources Division;
Human & Community Services Division;
Operations and Technology Division;
Public Health and Safety Division;

Quality Assurance Division, and
Senior and Long Term Care Division.

The majority of state level activities and services to the maternal and child population take place within the Public Health and Safety Division (PHSD). The mission of PHSD is to "Improve and protect the health and safety of Montanans." Jane Smilie has been the administrator of the Division since January 2005. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The State's public health system is a complex, multi-faceted enterprise, requiring many independent entities to unite around the goal(s) of health improvement and disease prevention at the community-level. These entities include local City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The public health system is a part of the continuum of care available to the citizens of Montana and the PHSD promotes and supports both the availability and the quality of public health services available to Montanans. The Division is organized into six bureaus:

Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
Communicable Disease & Prevention Bureau - Bruce Deitle, Acting Bureau Chief
Family and Community Health Bureau - JoAnn Dotson, Bureau Chief
Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
Laboratory Services Bureau - Anne Weber, Bureau Chief
Public Health Systems Improvement and Preparedness Bureau - Bob Moon, Bureau Chief

The Health Resources Division administrator is Chuck Hunter. The division brings together health resources for children, including CHIP, Children's Special Health Services, and the Children's Mental Health Program. In addition to the children's services, the division houses the primary care and hospital portions of Medicaid. This division is organized into six bureaus:

Acute Services Bureau -- Duane Preshinger, Bureau Chief
Children's Mental Health Bureau -- Pete Surdock, Bureau Chief
Fiscal Services Bureau -- Beckie Beckert-Graham, Bureau Chief
Health Care Resources Bureau -- Jackie Forba, Acting Bureau Chief
Hospital and Clinical Services Bureau -- Brett Williams, Bureau Chief
Managed Care Bureau -- Mary Angela, Bureau Chief

Maternal and Child Health Services as described in the Title V of the Social Security Act are the responsibilities of the Family and Community Health Bureau (FCHB) and the Health Care Resources Bureau (HRB).

The Family and Community Health Bureau has a staff of 30 and a total budget of approximately \$21 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Maternal Child Health Data Monitoring -- position vacant
WIC/Nutrition -- Chris Fogelman, Supervisor
Women's and Men's Health -- Suzanne Nybo, Supervisor

The Health Care Resources Bureau (HCRB) has 18 staff members and an annual budget of approximately \$16 million. The bureau is organized in two sections:

Children's Special Health Services (CSHS) -- BJ Archambault, Acting Supervisor
Children's Health Insurance Plan (CHIP) -- Jackie Forba, Supervisor.

An organizational chart of the Montana Department of Public Health and Human Services is available at <http://www.dphhs.state.mt.us/aboutus/orgcharts/orgchart.shtml>. Organizational charts for the Public Health and Safety Division, the Family and Community Health Bureau, and a combined Human Resources Division and the CHIP/CSHS Bureau are attached as a single document.

/2007/ The Department of Public Health and Human Services had a new director appointed in 2005. Joan Miles, JD, is the former director of the Lewis and Clark County health department. Director Miles also worked as a clinical laboratorian in the state and was a Montana state legislator.

The Family and Community Health Bureau has a staff of 32 and a total budget of approximately \$21 million, including funding from 13 federal and state sources. The FCHB bureau management includes:

Family and Community Health-- Jo Ann Walsh Dotson, Bureau Chief and MCH Director
 Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
 Children's Special Health Services (CSHS) -- Mary Runkel, Supervisor and CSHCN Director
 Maternal Child Health Data Monitoring (MCHDM) -- Ann Hagen-Buss, Supervisor
 WIC/Nutrition -- Joan Bowsher, Supervisor
 Women's and Men's Health -- Colleen Lindsay, Supervisor //2007//

/2008/

The FCH Bureau is very lucky to have retained the excellent managers recruited in 2005 and 2006. The listing of bureau leadership is the same as the list included in the 2007 update. Searches are in process for a second epidemiologist, and for quality assurance/contracts specialists in CSHS, WIC, and WMH. As of September, 2007 the WIC and WMH sections are fully staffed. //2008// An attachment is included in this section.

D. Other MCH Capacity

The MCHBG supports 10.69 FTE at the state level. These FTE are all or part of 16 staff members' time. The amount of FTE supported by MCHBG and the role of the staff member are described below:

| Section | Staff member | FTE Paid by MCHBG | Role |
|----------------------------|-------------------|-------------------------|-------------------------------|
| CACH | | | |
| | Dennis Cox | 1 | Adolescent/School Health |
| | Deborah Henderson | 0.5 | CACH Section Supervisor |
| | Wilda McGraw | 1 | FICMR, Child Health |
| | Cindy Mitchell | 0.5 | Admin Support |
| | Cheri Seed | 0.5 | Oral Health |
| | Sandra Van Campen | 0.5 | PHHV/FAS Prevention |
| MCHDM | | | |
| | Sib Clack | 0.35 | NB Screening & Birth Defects |
| | Kindra Elgen | 0.50 | MCH Data Manager |
| | Rosina Everitte | 0.17 | MCH Epidemiology/Statistician |
| | Jack Lowney, | 1.00 | MCHBG & Contracts |
| Subtotal of CACH and MCHDM | | 6.02 | |
| CSHS | | | |

| | | |
|-----------------|-------|--|
| Archambault, B. | 1.00 | Nurse Consultant and Acting Supervisor |
| Donnelly, M. | 0.80 | Nurse Consultant and Data System |
| Gruby, T. | 0.87 | Accountant |
| O'Donnell, M. | 1.00 | Clinic Coordinator |
| Scott, C. | 1.00 | Outreach Coordinator |
| Subtotal | 4.67 | |
| Total | 10.69 | |

Jo Ann Dotson's time is cost allocated across the bureau based on staff time, incorporating some MCHBG based on 6.02 FTE. Jackie Forba's time is fully covered by CHIP.

The FCHB Bureau has a staff of 30 and the HRB a staff of 18. All other FCHB state staff and portions of the MCHBG supported staff are paid from other funding, including federal funds (WIC, Title X, Newborn Hearing Screening, SOHCS, SSDI and FAS) and a small portion of general fund. HRB staff outside of the CSHS program is supported by a combination of federal CHIP and state match.

FCHB has one federal staff person, Dianna Frick, who is responsible for coordinating the 2005 needs assessment and the subsequent MCH needs prioritization and strategic planning. Dianna's position will be in existence for two years (Sept. 2004-Sept. 2006) and is a result of FCHB's successful application for a Public Health Prevention Service fellow through the Centers for Disease Control and Prevention.

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated -- for SFY 04, that estimate is for approximately 5.3% of the total budget. In addition, state law allows local health departments to use up to 10% of their funds for administrative purposes. Local agencies have been reported approximately 7.2% of their expenses as administrative costs.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. MCHBG is distributed to 54 of the 56 counties through MCH Contracts. Those amounts are based on an allocation formula that considers target population and poverty levels. The amount of funding obviously impacts the amount of time and subsequent work, which may be "purchased" with the dollars -- some of the smallest counties receive only \$1,000. The funding does require that a designated individual be available to monitor MCH needs. According to the Montana 2004 County Health Profiles, there were approximately 124 public health nurses, 84 registered sanitarians, 14 registered dietitians and 41 health educator FTEs in public health settings across the state. The MCHBG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Public Health Data System (PHDS) is a system developed for local health departments to use for case management and project reporting. SSDI funding helped in the initial development phases. The system is supported with approximately \$25,000 annually -- to date that amount has been matched or exceeded by various other sources, including Preventive Health Block Grant, Immunizations and Title X. While still a work in progress, the concept of common reporting software is crucial to accurate assessment and documentation of public health services. Administration of the PHDS has been transferred to the Public Health Informatics Section in the Division. The Health Resources Bureau maintains a Family Health Line. Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line with which Montanans can access information about health care programs for children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to CHIP (the Children's Health Insurance Plan), but approximately one-fourth of the nearly 12,390 phone calls received in 2004 has a referral component, in which the caller is referred to programs, both public and private, including those

administered under Montana's Maternal and Child Health Block Grant. The National March of Dimes Toll Free line now provides consumer and provider call in services, with back up teratogenic counseling and assessment available. Montana continues to support the concept of a nationally supported toll free line, similar to the Poison Control Line system created approximately 25 years ago.

March of Dimes and is the Region VIII Councilor for the Association of Maternal Child Health Programs.

//2007/ The FCHB experienced extensive staff changes during 2005-2006, due in part to retirements and family members moving out of state. Four of the bureau's five sections have new managers, including the CSHS, which was vacant for approximately 2 years. The MCHBG supports 12.25 FTE at the state level.

| Employee name | Section | Role |
|--------------------|---------|---|
| Dennis Cox | CACH | Adolescent/Youth Suicide Prevention (vacant as of 7/31/06), currently recruiting |
| Deborah Henderson | CACH | Section Supervisor |
| Julie Chafee | CACH | FICMR, Child Health, School Health - hired in 2006 |
| Candy Burch | CACH | Admin Support - hired in 2006 |
| Rae Brown | CACH | PHHV, FASD Prevention - hired in 2006 |
| Ann Hagen-Buss | MCHDM | Section Supervisor - hired in 2006 |
| Camie Zufelt | MCHDM | Data Manager - hired in 2006 |
| Shannon Koenig | MCHDM | Admin Support - hired in 2006 |
| Theresa Gruby | MCHDM | Accountant & Contracts |
| Margaret Virag | MCHDM | Oral Health - hired in 2006 |
| Mary Runkel | CSHS | Section Supervisor - hired in 2006 |
| Mary Lynn Donnelly | CSHS | Nurse Consultant and Data System |
| Michelle O'Donnell | CSHS | Clinic Coordinator |
| Corliss Scott | CSHS | Admin Support and Outreach |
| Sib Clack | CSHS | NB Screening & Birth Defects |
| Shari Pettit | CSHS | Nurse Consultant |
| Rosina Everitte | FCHB | MCH Epidemiology/Statistician (vacant as of 7/15/06, Dianna Frick hired and will begin 9/18/06) |

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed.
//2007//

//2008/The FCHB had limited staff changes during the last year, with most of the new staff hired in 2007 experiencing great success in their new roles. The Bureau staff is at present 39, with the MCHBG supporting 12.35 of those staff at the state level. Approximately 42% of the MCHBG also continues to be distributed through formula to 54 of the state's 56 counties, supporting the delivery of MCH services statewide.

//2008//

E. State Agency Coordination

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a relatively easy process. The fact that a few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. Everyone knows everyone and many clients are served in common. People work diligently to meet local client needs as

efficiently and effectively as scarce resources allow. Local input is sought at the state level, usually in the form of advisory councils or committees and functional work committees.

There are two Advisory Councils that advise the department on programs and services in the Family and Community Health Bureau and the Children's Special Health Services program. The Family and Community Health Bureau Advisory Council is charged with advising "... the Family and Community Health Bureau (FCHB) and the Department of Public Health and Human Services on matters impacting the Bureau's target populations, including pregnant women, women of childbearing age, infants, children to aged 22." The AC Purpose and Guidelines document and the list of 05-06 members is attached. The Council meetings every two months via TC, and advises the department in the interim via e-mail and by phone.

The Family and Community Health Bureau Advisory Council is instrumental in helping link and guide the Bureau. In Calendar 06, the Bureau will undergo a strategic planning update, facilitated by the PHPS and informed by the needs assessment submitted in this application. The strategic planning process will include AC members, contractor representatives, program managers and staff. The FCHBAC members provided effective advocacy for MCH programs during the 2003 and 2005 State Legislature and played key roles in preserving the state's general fund support of the public health home visiting program for high-risk pregnant women and infants addressed in legislation as Montana's Initiative for the Abatement of Mortality in Infants or MIAMI.

The Children's Special Health Services (CSHS) section is located in the Health Care Resources Bureau and coordinates services and activities directly with providers through the Montana Chapter of American Academy of Pediatrics, an advisory committee, public payers such as SCHIP, state employee benefits plan and Medicaid, the Family Voices chapter housed at Parents Lets Unite for Kids (PLUK), the Insurance Commissioners Office and others. CSHS continues to expand their ability to coordinate services with other partners who work with CSHCN. In Montana much of this activity occurs at the local level through service providers. CSHS also works towards coordination at the state level. The State CHIP program is also contained in the HCRB and collaboration with Medicaid is an integral part of operations. The CSHS section receives input and guidance from an advisory group consisting primarily of medical providers, but also including parent participants and advisors. Jo Ann Dotson, the Bureau chief of the Family and Community Health Bureau participates as a staff member on the CSHS Advisory Group.

The PHSD and FCHB also have other Advisory Councils. At present, the PHSD has approximately 35 councils, many of them linked to specific grants. The FCHB has The Birth Outcome Monitoring AC, The Dental Access Coalition, the Family Planning Medical Standards Committee, Fetal Alcohol Syndrome Advisory Council, Fetal Infant & Child Mortality Review Work Group, the Newborn Hearing Screening Task Force, Newborn Screening Advisory Board, the Suicide Prevention Work Group and the WIC Steering Committee. The Governor's office is examining all ACs, and anticipating combining some of these functions into the FCHB AC structure, which will be done over the next year.

FCHB and HRCB Staff participates on several intra and interagency groups targeting the MCH population. Examples of those groups include:

Connecting for Kids -- Primarily designed as an intra agency group, this group began meeting in 2004, in order to address challenges of linking existing programs and services. Programs, including DD, foster care, and others, were facing instances in which children's insurance or other services stopped with no transition plan. This group's stated purpose is to "... look at the systems that serve children in Montana, to enhance coordination of programs, and improve communications between programs to deliver services in the most efficient manner possible".

Healthy Kids - Quarterly meetings are held with the Office of Public Instruction (which is the state's Department of Education) in order to discuss issues that cross departmental boundaries, such as dispensing medications in the schools, management of biohazards in schools and

management of asthma. Dennis Cox helps facilitate that group, setting the agenda every other meeting.

Kid's Count Advisory Council -- This project is directed by the Bureau of Business and Research of the University of Montana. Funded in Part by the Annie E. Casey Foundation, this project helps to inform health policy discussion and decisions. The project publishes and distributes a Montana specific report every year. This advisory council meets quarterly. The department also supports the printing and distribution of the Kids' Count Book to local communities.

March of Dimes Board of Directors -- This board meets monthly. Jo Ann Dotson represents public health on this board. The Bureau shares common goals to improve pregnancy outcomes and decrease infant mortality, including that attributable to prematurity, with the March of Dimes organization.

/2007/Reorganization resulted in the move of the CSHS section to the Family and Community Health Bureau effective January 1, 2006. The CSHS Advisory Committee now functions as a subcommittee to the Family and Community Health Bureau Advisory Council. An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

/2008/

As noted above, the Primary Care Office was moved to the Family and Community Health Bureau effective January 1, 2007.

The "Connecting for Kids" group has been examined over the last year. The focus on developing a system of care for children's Mental Health has emerged as a top priority, and a system of care Committee created. The Connecting work group continues to meet to deal with individual client needs, but the primary effort has shifted to the System of Care. Bonnie Adey, the former ombudsman in the Governor's Office assumed the role of Children's Mental Health Bureau Chief in 2006, and is guiding the development of a system of care statewide. FCHB staff have participated in the meetings, and will continue to monitor progress of that effort.

FCHB Managers, four of 5 whom were hired in 2006, have become valuable members of many agency and statewide organizations. Mary Runkel (CSHS Manager) was invited to participate on a Montana Academy of Pediatrics subcommittee, and participated as the state level participant in the Genetics Meeting in Denver this spring. Joan Bowsher (WIC Manager), a former county agency preparedness division leader, was asked to represent MCH on the state level Preparedness Planning Committee. Ann Hagen-Buss (MCHDM Manager) and Deborah Henderson (CACH Manager) are working with the Human and Community Services Division as they expand oral health and home visiting services and implement the Early Childhood Services project in partnership with the Early Childhood Services Bureau in that division. Colleen Lindsay (Women's and Men's Health Manager) was also asked to participate in an advisory capacity in the development of a comprehensive sexual health education proposal which may be submitted in the next legislative session. Attached is a pictorial representation of each Section's numerous partnerships formed this past year.

The Bureau's Strategic Planning process resulted in a more concentrated focus on each section's current and formation of future partnerships with governmental and private organizations who support the National and State Performance Measures and the Health Systems Capacity Indicators and goals and objectives related to other grants managed within the Bureau. //2008//

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------|-------|-------|-------|-------|
| Annual Indicator | 14.2 | 11.1 | 14.9 | 54.1 | 52.7 |
| Numerator | 78 | 61 | 82 | 160 | 154 |
| Denominator | 54869 | 54869 | 54869 | 29557 | 29237 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2006

These data are from the Montana Medicaid program and the DOA and reflect both Medicaid and CHIP numbers. Due to the fact that the data are from claims data it reflects those children who were hospitalized and had asthma, not those that were hospitalized due to asthma.

Notes - 2005

Medicaid data were used to report on this indicator for 2005. Between 10/1/2004 and 9/30/2005, 167 children were hospitalized with an asthma diagnosis. During this same time, there were 27,473 children under age 5 enrolled in Medicaid.

UPDATE - The denominator and numerator have been updated with more recent numbers of enrollment for 2005. These data now reflect Medicaid and CHIP numbers. CZ

Narrative:

Montana's Department of Public Health and Human Services (DPHHS) had previously not had access to hospital discharge data. However, recently the Public Health and Safety Division acquired some hospital discharge data for 2000-2005. The data were not available in time for the July 15 submission of the block grant, but pending a review of the reliability and completeness of asthma data in the 2005 data, they may be included after the block grant review.

The data currently reported for this indicator are from CHIP and Medicaid. The numerator reflects the number of children who were admitted for hospitalization during 2006 who also had an asthma diagnosis code. Due to the way Medicaid data are collected, it is not possible to determine whether all of the hospitalizations were related to asthma. The results for this indicator have varied since 1998, and the number of children hospitalized who had asthma was quite low until 2005, with numbers less than 100. This is believed to be due to inadequate reporting, however, and not necessarily reflective of the true rate of hospitalizations. The rate prior to 2005 also appears low compared to HSI 01 results from other states and jurisdictions, although data sources vary so the comparability is questionable. Montana's 2005 source of data for this indicator is Medicaid paid claims data, which captures data for only a small subset of the actual population at risk. The data for 2005 were run using different criteria than in previous years, and as a result the percent of children hospitalized increases dramatically for the reporting year.

However, children in lower-income (and possibly Medicaid-eligible) households may be more at

risk for asthma due to quality of housing, limitations in medical care and exposure to other risk factors, so this rate may be higher than that of the general population. The recently hired Data Coordinator for the Family and Community Health Bureau completed training in Query Path, the Medicaid data system, in 2007 and has been working with Medicaid staff to determine how best to report for this indicator. In 2006, 154 children had Medicaid- or CHIP-paid hospitalizations for asthma.

Montana's Title V program does not have an asthma component, but the program does collaborate with projects related to asthma and healthy environments. Previously, Montana's Environmental Public Health Tracking (EPHT) Project is working with communities to identify the primary environmental health risks, some of which are possible risk factors for asthma. However, in 2006 the Environmental Public Health Tracking Project was not funded and the tracking activities have ceased. The 2007 Montana Legislature approved the use of general funds for asthma surveillance and control. As a result, the Chronic Disease Bureau of MT DPHHS recently initiated discussions regarding asthma activities and will soon be advertising for staff to manage an asthma program.

A new project called Healthy Air Daycare was initiated in 2005, with collaboration from the Title V program's Child Health Consultant. This program developed a checklist of environmental factors to be reviewed at each daycare site during licensing visits. If the daycare meets a certain criteria, it is awarded a "Healthy Air" sticker that can be placed in the window of the daycare. The program also results in the education of daycare providers about healthy indoor environments for the children they care for. Of the 186 childcare facilities that submitted Protect My Air checklists between 1/24/06 to 3/7/07, 185 of them met four of the six key indicators required to be called a Healthy Air facility.

Environmental health was identified as a priority area during the Family and Community Health Bureau's (FCHB) current strategic planning activities. FCHB is Montana's Title V program. Goals and objectives have yet to be developed for this priority area, but FCHB expects to explore partnerships related to environmental health, and possible ways to include environmental health education into existing programs. Some of the risk factors linked to asthma would be included in these efforts.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 84.3 | 87.0 | 84.3 | 88.3 | 22.7 |
| Numerator | 4077 | 4298 | 4359 | 4635 | 1160 |
| Denominator | 4836 | 4943 | 5172 | 5249 | 5106 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

Notes - 2006

This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FFY 2006.

Notes - 2005

This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004

This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2004, updated in 2006 with final data.

Narrative:

Montana's Medicaid program is in a different division than the state's Title V program. Collaboration does occur where appropriate around MCH-specific activities. For instance, the Children's Special Health Services (CSHS) section collaborated with Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program to promote the awareness of the medical home concept for CSHCN. Hearing and mandated genetic screening also occur for the majority of Montana's children, regardless of whether they are Medicaid enrollees or not. Efforts to increase the percent of infants screened are ongoing through the development of new partnerships, support of current relationships and exploration of new legislation or guidelines to support screenings.

The percentage of Medicaid-enrolled infants screened has ranged from 84% - 98% over the past five years. Due to the small size of Montana's population, 10 years of data might provide a more realistic indication of trend for this indicator. Changes in Medicaid policies, eligible population, access to providers, and other factors that could affect access to screenings and cause the data fluctuations are not reflected by the numbers. The variations in the five years reflected here indicate that Montana's percent of infants screened is staying about 80%.

The Family and Community Health Bureau submitted an application for the Targeted State MCH Oral Health Service Systems Grant Program with successful applicants to be notified by September 1, 2007. Included in this application were strategies specifically addressing how Community Health Centers could increase their numbers of EPSDT screenings.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 100.0 | 100.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 1 | 1 | 0 | 0 | 0 |
| Denominator | 1 | 1 | 1 | 1 | 1 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2006

Data are not available for this indicator.

Notes - 2005

A report of the CHIP data base children by age and by procedure codes is not available and is not feasible to program a new report in time to submit with the annual submission of MCHBG. In

addition the number of children under one year is not available on the state level vital statistics. Data entered is not correct.

Notes - 2004

A report of the CHIP data base children by age and by procedure codes is not available and is not feasible to program a new report in time to submit with the annual submission of MCHBG. In addition the number of children under one year is not available on the state level vital statistics. Data entered is not correct.

Narrative:

Montana's CHIP program does not collect data that can be used for this Health System Capacity Indicator. The data presented in HSCI02 are considered most indicative of this statistic even though children eligible for Medicaid in Montana are not eligible for CHIP. At this time MT CHIP has no plans to collect these data.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 78.4 | 79.6 | 81.1 | 80.4 | 79.1 |
| Numerator | 8529 | 9060 | 9214 | 9153 | 9728 |
| Denominator | 10873 | 11384 | 11355 | 11382 | 12303 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2005

The numerator is the number of women having 80% or better percentage for this measure. The denominator is birth cohort for the year in question.

These data were updated in 2007 to reflect the appropriate age range (15-44 years).

Notes - 2004

The numerator is the number of women having 80% or better percentage for this measure. The denominator is birth cohort for the year in question. These data were updated in 2007 to reflect the appropriate age range (15-44 years).

Narrative:

The data source for this indicator is vital records. Vital records data for 2006 are still provisional, so this number may shift slightly with finalized numbers. However, the preliminary indicator is similar to what has been reported in the past.

In 2005 and 2006, the percent of women with adequate prenatal visits according to the Kotelchuck Index decreased slightly. However, over the past 5 years, Montana has seen a trend towards an increase in prenatal visits.

The American Hospital Association Data reported a decline in the number of hospitals throughout the state providing obstetrical care, from 34 in 2004 to 32 in 2005. This number does not include Indian Health Services (IHS) facilities, and so is not a complete representation of delivery sites. However, it may indicate some limitations on where pregnant women can access prenatal and obstetric services.

Several programs coordinated through Montana's Family and Community Health Bureau (FCHB), the State's Title V program, contribute to education on and support for prenatal care. The Public Health Home Visiting (PHHV) program provides home visits to at-risk pregnant women. WIC offers nutrition education and resources. The Fetal, Infant and Child Mortality Review (FICMR) offers information on preventing premature births. As these programs have expanded and become more visible and known in communities over the past several years, the messages on prenatal care are reaching more and more women. Where possible, programs such as WIC are also connecting women with sources of prenatal care, such as Medicaid or private providers. County Health Departments that receive Title V funds (54 of 56 counties) also provide services on a sliding fee scale.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 86.6 | 86.7 | 88.7 | 88.7 | 86.1 |
| Numerator | 55526 | 46369 | 57700 | 58602 | 51200 |
| Denominator | 64089 | 53457 | 65079 | 66078 | 59448 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

Notes - 2006

This data came from the Montana Medicaid Program. It was pulled from MMIS the medicaid database using a querying system called QueryPath.

Notes - 2005

This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004

The trend analysis for 2000-2004 revealed continued decreases in the percent of children receiving services, and the true percentage for 2010 at approximately 75%. MCH has limited control over this program and subsequent performance measurement, including the actual yearly indicators and future projections.

Narrative:

These data come from the Montana Medicaid Program's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) report. The percent of eligible children who have received a Medicaid paid service has remained fairly steady over the past several years, although the number

dropped slightly in 2006. The reason for the drop is unknown.

Montana's Maternal and Child Health program has limited influence over Medicaid-provided programs. Several MCH programs collaborate with Medicaid to try to increase care or educate Medicaid providers and program staff on possible services and interventions. For instance, the WIC and Children's Special Health Service (CSHS) programs both assist their clients to verify whether they are eligible and initiate enrollment in Medicaid where appropriate. CSHS, the Child, Adolescent and Community Health (CACH) section and the Oral Health Education Specialist have all developed relationships with Medicaid to collaborate on programs that will help serve children and facilitate their access to Medicaid services.

Montana struggles with access to providers, particularly providers who will accept Medicaid, which certainly affects this indicator. As populations within the state shift towards larger population centers, rural areas are having more difficulty recruiting and keeping providers. Transportation challenges and distances involved in getting to a health provider can deter families from using services. In some of the state's population centers, providers are over-booked and it may be a challenge to find a physician accepting new patients or Medicaid-eligible clients.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 34.5 | 34.1 | 32.9 | 34.3 | 33.6 |
| Numerator | 3703 | 3849 | 3931 | 4182 | 4099 |
| Denominator | 10731 | 11276 | 11960 | 12182 | 12182 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2006

This data came from the EPSDT report from the Montana Medicaid Program. It is annual report for the FFY 2006.

Notes - 2005

This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004

This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2004, updated in 2006.

Narrative:

The percent of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible children who have received dental services during the year has remained fairly steady and low over the past five years, never above 35%.

Montana's maternal and child health (MCH) program has limited ability to affect Medicaid

programs. However, the Oral Health Education Specialist (within the MCH program) has collaborated with Medicaid on dental access issues.

Montana struggles with a shortage of dental professionals in the state. The shortage is even more severe in rural areas and when considering dentists who accept Medicaid and child clients. For children with behavioral problems or special needs, finding a dentist who will accept them as a client can be even more challenging. There were 361 dentists and denturists in Montana who accepted Medicaid clients during state fiscal year 2005 (7/1/04 to 6/30/05) and 332 in state fiscal year 2006 (7/1/05 to 6/30/06), a decline of 29 in a one-year period. As of December 31, 2005, CHIP had 269 dentists practicing in 279 locations, leaving 14 Montana counties (25%) with no CHIP enrolled dentist. As of December 31, 2006, there were 252 dentists treating CHIP-eligible children. According to the Montana Primary Care Office, 37 of Montana's 56 counties are designated as Dental Health Professional Shortage Areas

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 2.1 | 0.8 | 1.0 | 1.1 | 0.0 |
| Numerator | 33 | 12 | 18 | 22 | 0 |
| Denominator | 1600 | 1555 | 1892 | 1957 | 1 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

Notes - 2006

Children who receive SSI services are automatically receiving Medicaid according to the state statute. Therefore, all services for SSI children received through the Children with Special Health Care Needs Program are paid through Medicaid. CZ

Notes - 2005

This indicator is essentially unchanged for 2005, although it was predicted to change significantly from 2004 due to CSHS ability to provide resource and referral information to this population. This service was not instituted until May of 2006 and therefore has not yet affected the reporting of this measure. Medicaid coverage for eligible applicants continues to provide for rehabilitative services. CSHS continues to cover some genetic testing for Medicaid clients in out of state labs that are Montana Medicaid providers. During FFY 2005, 22 SSI beneficiaries received comprehensive evaluation through a Title V sponsored Cleft/craniofacial or Metabolic clinic, not paid for by Medicaid.

Notes - 2004

This indicator is essentially unchanged for 2004. It will change significantly in 2005, due to the capacity CSHS has developed to provide resource and referral information to this population. Medicaid coverage for eligible applicants continues to provide for rehabilitative services. In addition, CSHS is providing resource information to SSI applicants who are not deemed eligible for SSI.

Narrative:

During a review of the guidance for this indicator, and discussions with the Montana Children's Special Health Services Program, it was determined that no children meet the criteria to be reported in the numerator for HSCI 8. The guidance states the goal of this HSCI as "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title XVI, to the extent medical assistance for such services is not provided by Medicaid." In Montana, all children eligible for SSI are also eligible for Medicaid. It was determined that in 2006 no SSI beneficiaries under 16 in Montana received services through the CSHCN program that were not paid for by the Medicaid program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|-------------|------------|--------------|-----|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of low birth weight (< 2,500 grams) | 2006 | other | 7.2 | 7.2 | 7.2 |

Notes - 2008

This information was not available from Medicaid and no alternative estimates were available. Therefore, the percent of low birthweight reported for the Medicaid and non-Medicaid populations is reported as the same as the overall population. Payment source are not yet available on the birth certificate. A revised BC will be implemented January 1, 2008 and data will be available in 2009. These data were updated for the September resubmission. DF

Narrative:

Vital statistics records do not currently capture payment source related to birth records. The data presented above do not actually represent the percent of low birthweight in the Medicaid and non-Medicaid populations. At the time of the block grant submission, discussions were underway about whether low birthweight data were available through Medicaid. Because low birth weight is collected as a risk code and not as a part of claims data, there were some doubts about the accurateness of using the risk code to determine the percent of Medicaid births that were low birthweight. Preliminary results indicated that there were approximately 4346 births covered by Medicaid during 2006, and 72 births that had some sort of low birth weight coding, which would result in 1.7% low birth weight. These preliminary data indicate that Medicaid paid for 35% of the births, and those births accounted for only 8% of the low birth weight infants. Because of the known limitations with how the low birth weight Medicaid data are collected, and because the preliminary percent of low birth weight is so low for the Medicaid population, this was determined not to be an accurate representation of low birth weight among Medicaid-paid births. At the time of block grant submission, Medicaid staff were running a more detailed report on the available data to determine what could be gleaned from Medicaid records.

A new birth certificate will be implemented in 2008 that collects payment source for births. For detail on low birth weight-related activities in Montana, please see the narrative for State Performance Measure 8.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|-------------|------------|--------------|-----|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Infant deaths per 1,000 live births | 2006 | other | 4.8 | 4.8 | 4.8 |

Notes - 2008

This information was not available from Medicaid and no alternative estimates were available. Therefore, the infant deaths per 1000 live births reported for the Medicaid and non-Medicaid populations are reported as the same as the overall population. Payment source are not yet available on the birth certificate. A revised BC will be implemented January 1, 2008 and data will be available in 2009. These data were updated for the September resubmission. DF

Narrative:

Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. The Montana Office of Vital Statistics recently linked infant birth and deaths records, which may provide a data source for this measure when data from the new birth certificate are available. Infant death data may also be available through Medicaid claims data. New Medicaid staff are working with Bureau staff to identify Medicaid data that could be used to report on block grant indicators. Data were not available at the time of the block grant submission.

Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|-------------|------------|--------------|------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2006 | other | 83.2 | 83.2 | 83.2 |

Notes - 2008

This information was not available from Medicaid and no alternative estimates were available. Therefore, the percent of infants born to pregnant women receiving care beginning in the first trimester for the Medicaid and non-Medicaid populations is reported as being the same as the overall population. Payment source are not yet available on the birth certificate. A revised BC will be implemented January 1, 2008 and data will be available in 2009. These data were updated for the September resubmission. DF

Narrative:

Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|---|------|-------------|------------|--------------|------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) | 2006 | other | 79.1 | 79.1 | 79.1 |

Notes - 2008

This number only includes women 15-44 at the time of the birth.

This information was not available from Medicaid and no alternative estimates were available. Therefore, the Kotelchuck Index for the Medicaid and non-Medicaid populations is reported as the same as for the overall population. Payment source are not yet available on the birth certificate. A revised BC will be implemented January 1, 2008 and data will be available in 2009. These data were updated for the September resubmission. DF

Narrative:

Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
|---|------|-----------------------------------|
| Infants (0 to 1) | 2006 | 133 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Infants (0 to 1) | 2006 | 150 |

Narrative:

These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid in Montana is lower than in other states nationwide (according to TVIS data for 2004) for infants, but similar to other states in the region. For CHIP, a comparison of Montana's poverty level-related eligibility for infants shows that it is lower than the majority of other states nationwide and within the region. However, effective July 1, 2007 the income guidelines for CHIP were changed from 150% to 175% of FPL (\$36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs. The anticipated impact is for an additional 2,100 children to be enrolled in CHIP, for a total enrollment of approximately 16,000 children.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
|---|-------------|--|
| Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to) | 2006 | 133 100 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Medicaid Children (Age range 1 to 18) (Age range to) (Age range to) | 2006 | 150 |

Narrative:

These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid in Montana is lower than in other states nationwide (according to TVIS data for 2004) for infants, but similar to other states in the region. For CHIP, a comparison of Montana's poverty level-related eligibility for infants shows that it is lower than the majority of other states nationwide and within the region. However, effective July 1, 2007 the income guidelines for CHIP were changed from 150% to 175% of FPL (\$36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs. The anticipated impact is for an additional 2,100 children to be enrolled in CHIP, for a total enrollment of approximately 16,000 children.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
|---|-------------|--|
| Pregnant Women | 2006 | 133 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |

| | | |
|----------------|--|--|
| Pregnant Women | | |
|----------------|--|--|

Notes - 2008

CHIP does not cover pregnant women over the age of 18.

Narrative:

These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid is lower than most other states (according to TVIS data for 2004) for pregnant women, but the same as other states in the region. Montana's CHIP program does not cover pregnant women over 18 years of age.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| DATABASES OR SURVEYS | Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) | Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N) |
|--|---|---|
| <u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates | 2 | No |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 1 | No |
| Annual linkage of birth certificates and WIC eligibility files | 1 | No |
| Annual linkage of birth certificates and newborn screening files | 3 | Yes |
| <u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges | 2 | Yes |
| Annual birth defects surveillance system | 1 | Yes |
| Survey of recent mothers at least every two years (like PRAMS) | 1 | Yes |

Notes - 2008

Narrative:

The Family and Community Health Bureau (FCHB), Montana's Title V Program, does not have purview over the majority of the databases and surveys mentioned, with the exception of WIC, PRAMS, newborn screening, and the birth defects surveillance system. Therefore, while the Bureau is often involved in discussions regarding vital statistics data and linkages, it may not be

the decision-maker.

Montana's Office of Vital Statistics recently linked infant birth and death records for a limited time period. They are moving towards linked birth and death records for a broader time period and population, but no estimated completion date has been set.

FCHB does have access to de-identified birth records and the death records for 1989-2005, but these files are not linked. FCHB has access to Medicaid claims files through a staff member trained in Query Path, the Medicaid data system, and by submitting requests to Medicaid staff. Medicaid claims data are not linked to birth records. Some small studies have been undertaken in MT DPHHS to link Medicaid claims data with vital records. A similar activity is planned by FCHB as a part of the SSDI grant for the 12/1/07-11/30-08 budget period. This activity will help to determine the feasibility of linking Medicaid and birth records for specific analyses, and possibly on a more ongoing basis.

The WIC data system is expected to undergo an upgrade over the next several years. The current system is somewhat unwieldy and is not linked to birth certificates. FCHB does have access to WIC data, but not linked WIC-birth certificate data.

Efforts to link birth certificates and newborn screening data are currently underway. A linkage is available to some extent, but links for the reporting year are sometimes not available in time for block grant submission. The Newborn Screening Coordinator in the Children's Special Health Services Section of FCHB is coordinating the effort.

Some hospital discharge data for 2000-2005 were obtained by the Public Health and Safety Division in 2007. The data are expected to be available in future years, pending negotiations with the Montana Hospital Association.

Montana has birth defects surveillance data through 2005. Active collection of birth defects data was suspended in 2005 when the newborn screening grant application to CDC was approved but unfunded. Discussions continue regarding possible future methods of collecting and using birth defects data. All of the data collected thus far are maintained by FCHB.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for a PRAMS grant in 2006 was not successful. The 2002 data are maintained by FCHB. At this time, FCHB is unable to conduct an independent PRAMS-like survey due to funding and staff limitations. However, possible additional and alternative data sources continue to be explored. MCH data capacity development was identified as a Bureau priority during strategic planning.

The Montana Assessment project was initiated in late 2006 to review the data systems of the Public Health and Safety Division (including the MCH data systems) and determine an inclusive process for future review and revision of public health data systems. The project will be completed in 2007 with recommendations for a data review process.

In May of 2007, the Family and Community Health Bureau MCH Epi Unit conducted an assessment and planning project for epi activities. Roger Roachat, an MCH Epidemiologist at Emory University, and the FCHB MCH Epidemiologist conducted interviews with Bureau staff and partners to identify priority MCH epi activities, including data linkages and analyses. The final report will be available at the end of July.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS | Does your MCH program have direct access to the state YRBS database for |
|--------------|---|---|
|--------------|---|---|

| | survey? (Select 1 - 3) | analysis? (Select Y/N) |
|-----------------------------------|-----------------------------------|-----------------------------------|
| Youth Risk Behavior Survey (YRBS) | 3 | No |

Notes - 2008

Narrative:

Montana's Office of Public Instruction (OPI) conducts and maintains the data from the Youth Risk Behavior Survey. While the raw data are not available to the Title V program, the results of the survey are distributed in published form, and are also easily searchable and obtainable from the OPI website or the national YRBS website. The YRBS has been conducted in Montana every other year since 1993, with the most recent results available for 2006. Montana's Title V program frequently uses YRBS data for grant applications and reports, and it was a valuable source of information for the five-year maternal and child health needs assessment.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Montana's maternal and child health needs assessment process is continuous. Data are collected and analyzed throughout the five-year period. The needs assessment document is an opportunity to compile data and reflect on the complete picture of MCH needs and programs in Montana. Following the submission of the 2005 MCH needs assessment, and using the assessment as a guide, Montana's Family and Community Health Bureau (FCHB) will begin a strategic planning process to further prioritize MCH needs and identify how the FCHB can address them. The strategic planning process will continue the assessment process and ensure the use of previously collected assessment data. In addition, questions were included on the stakeholder survey sent to providers regarding how the process could be useful to them. The needs assessment results will be distributed to stakeholders around the state and available on the state website, which will help to generate interest in the process and encourage use of the needs assessment results. Finally, counties receiving MCH block grant funds are required to conduct their own needs assessments every five years, and those results are incorporated into the state's data collection process.

Beginning in 2002, meetings were held at the state level to determine how the state would develop the needs assessment. The Family and Community Health Bureau within the Montana Department of Health and Human Services submitted applications for two student interns in 2003. The students were responsible for conducting key informant interviews with stakeholders throughout the state and updating data from the 2000 needs assessment during June-August of 2004. FCHB also submitted an application for a Centers for Disease Control and Prevention Public Health Prevention Specialist to be assigned to Montana to assess the needs of the MCH populations. The prevention specialist arrived in Montana at the end of August, 2004.

Two groups at the state-level were primarily responsible for shaping and directing the needs assessment process: the Family and Community Health Bureau Advisory Council (FCHB AC) and the Family and Community Health Bureau Managers. The FCHB AC includes representatives from partner organizations throughout the state, including the March of Dimes, local health officers, WIC, family planning, education, urban and rural local health departments, Indian Health Services, nurses associations, and providers. The Council was involved in determining the approach and the final format of the needs assessment survey, as well as reviewing the final document. The FCHB AC will also be an integral part of the strategic planning process and the ongoing prioritization of maternal and child health needs and activities.

The Family and Community Health Bureau Managers is comprised of the chief of the Family and Community Health Bureau and the managers of the four sections of the Family and Community Health Bureau: Maternal and Child Health and Data Monitoring; Child, Adolescent and Community Health; Women's and Men's Health; and, Women Infants and Children (WIC)/Nutrition. The managers decided the approach and focus of the community participation component of the needs assessment, participated in the development of the surveys, and reviewed and advised on the content of the final needs assessment document.

//2008/ This past year the five sections continued to update the section workplans, which are based on the goals and objectives outlined in the FCHB strategic plan. Each section's workplan includes their specific action steps for achieving the goals and objectives outlined in the FCHB Strategic Plan. The FCHB strategic plan was in turn based on the results of the statewide 2005 MCH Needs Assessment. Each section conducts periodic reviews of their workplan and updates their progress in achieving the activities related to the eight priority areas. The FCHB Section Managers and the Bureau Chief have begun discussions on planning for the 2010 Needs Assessment. It is anticipated that the Governor-appointed Family Health Committee, formerly the FCHB Advisory Council, will be actively involved in the 2010 Needs Assessment process. //2008//

B. State Priorities

Selection and prioritization of state needs is an ongoing process requiring assessment of health status and system functioning indicators as well as availability of financial and human resources. Changing expectations of public health impacts the priority selection. The evolution of public health in Montana and the nation continue, moving from what was essentially individually-based services, often providing primary care or a proxy for primary care services towards a system that is population-based, including needs assessment, policy development and assurance. Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent in communities where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure.

The following list of priority needs was generated based on a statewide survey of consumers and those caring for infants, children and families. A copy of the consumer and professional survey is attached to this section. The survey was distributed to WIC and Head Start clients, WIC and Head Start program staff and primary care and public health providers.

This survey provided public input into the development of a list of priority needs, which was further assessed based on the following criteria:

- Existence of data supporting the need
- Evidence that the MCH population, including infants, children, adolescents, children with special health care needs, women of childbearing age and their families were the target audience of the priority.
- Availability of resources and capacity within the public health system (not necessarily the MCH agency) to help address the issue.

This priority list will be the basis of the strategic planning process, which will involve the FCHB Advisory Council, the FCHB staff and local partners and consumers during FFY 06. The needs assessment will inform participants in the strategic planning process. It is anticipated that further prioritization will take place during the strategic planning process, and that the priority list will continue to change and evolve as new data, which will be part of the ongoing needs assessment, is revealed.

This list does not address overarching issues, which impact every one of the priorities. The issues include:

- The importance of a functioning public health system -- the public health system addresses the core functions of public health including assessment, policy development and assurance through the essential services. Included in those services are the responsibility to have appropriate training of public health professionals and partners, epidemiological capacity with which to analyze information regarding the population, and excellent networking among traditional and non-traditional public health providers.
- Recognition of disparity and its impact on the health of the MCH population. -- Examples include disparity in the efforts to promote the health of females in society, as well as disparity between ethnic groups, age groups (i.e. school-aged children) and urban and non-urban dwellers. Recognition of, and efforts to address these disparities is an overriding concern, as they impact all MCH priorities.

Priority Issues

1. Increase access to health care for MCH populations, including children with special health care needs.
2. Increase insurance coverage of MCH populations.
3. Promote and improve oral health services for MCH populations.

4. Reduce the rate of intentional injuries in MCH populations, including, but not limited to the incidence of domestic violence and youth suicide.
5. Promote and support families to raise children in safe and nurturing environments.
6. Reduce the rates of preventable illness in children and adolescents, including obesity and vaccine preventable illnesses.
7. Prevent substance use in MCH populations.
8. Promote access to mental health services for MCH populations.
9. Promote efforts to continue to decrease the incidence of unintended pregnancies.

Efforts to update and re-examine priorities are done annually, in the form of pre-contract surveys to all contract counties. The surveys are distributed in February of each year, and elicit county responses on topics such as the priority needs impacting the MCH target populations. The Family and Community Health Bureau Advisory Council receives and reviews summaries of the annual pre-contract surveys. Staff also has the responsibility to monitor data and available statistics.

/2007/

For the 2007 MCH Block Grant (MCHBG) submission, Montana adjusted the state's priorities to reflect the priority areas in the newly-developed Family and Community Health Bureau (FCHB) strategic plan. FCHB is Montana's Title V program. The revised list of FCHB priorities is below (please note that the priorities are not ranked). Underneath each priority is a list of any related state and national performance measure(s). The new priority areas are based on discussions and strategic planning activities, and are an evolution from last year's priorities, which were in turn based on the 5-year MCH needs assessment. The priorities listed in this year's MCHBG application are expected to stay the same for the next 5 years, although periodic reviews of the strategic plan may result in some revised and updated priority areas. A discussion of the strategic planning process and the development of this year's priorities follows the list of priority areas.

State Priorities

1) Environmental health

Montana expects to develop a state performance measure related to environmental health in the future. A new project called Healthy Air Daycare, which assesses the environmental health of daycares as a part of licensing visits, has recently been implemented and data are expected to be available within the next year.

2) Family support and education

NPM 2, NPM 3, NPM 5, NPM 6, NPM 8, NPM 10, NPM 11, NPM 15, NPM 16

SPM 1 (unintended pregnancy)

SPM 4 (fetal, infant and child deaths reviewed for preventability)

SPM 7 (firearm deaths among youth aged 5-19)

3) Mental health and substance abuse

NPM 8, NPM 15, NPM 16

SPM 2 (abstaining from alcohol use during pregnancy)

SPM 4 (fetal, infant and child deaths reviewed for preventability)

SPM 6 (abstaining from cigarette smoking during pregnancy)

4) Nutrition and obesity prevention

NPM 11, NPM 14

5) Promotion of preventive and accessible health care

NPM 1, NPM 2, NPM 3, NPM 4, NPM 5, NPM 6, NPM 7, NPM 9, NPM 12, NPM 13, NPM 17, NPM 18

SPM 5 (Medicaid-eligible children who receive dental services)

6) Reproductive and sexual health

NPM 8, NPM 15, NPM 17, NPM 18
SPM 1 (unintended pregnancy)
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 6 (abstaining from cigarette smoking during pregnancy)

7) Unintentional injuries

NPM 10

SPM 4 (fetal, infant and child deaths reviewed for preventability)

SPM 7 (firearm deaths among youth aged 5-19)

8) Family and Community Health Bureau capacity development

FCHB capacity development relates to all of the performance measures. Increased staff capacity in data management, organizational relationships and management skills will contribute to their work in all MCH areas.

Strategic Planning Process

Subsequent to the completion of Montana's five-year MCH Needs Assessment in 2005, FCHB began to develop a five-year strategic plan. Two large stakeholder meetings were held in late 2005. The meeting participants included FCHB staff, FCHB Advisory Council Members, Children's Special Health Service (CSHS) Advisory Council members, and other Department of Public Health and Human Services (DPHHS) partners in MCH activities.

The first meeting, in October, established the drafts of the vision, mission, guiding principles and priority areas. The priority areas were based on the results of the statewide MCH needs assessment. Following the meeting, a small workgroup was formed for each of the priority areas, and the workgroup members developed goals and objectives related to each area.

The second large stakeholder meeting, in December, used the CAST-5 tool to identify and discuss FCHB capacity needs. Holly Grason, of Johns Hopkins University, was the facilitator. The following capacity needs were identified as priorities:

Data Capacity:

- Adequate data infrastructure (access to more and better data/strategic use of data)
- More capabilities related to translation and communication of data
- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis

Organizational Relationships:

- Improved collaborative working partnerships with state and local health programs
- Expanded relationships with additional stakeholders, policy makers, advocacy groups, funders, and the business sector

Skills:

- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis
- Enhanced management and organizational development skills among staff

Three small workgroups, one for each capacity need topic area, were formed to brainstorm current activities and desired activities related to each capacity need. The brainstormed ideas were then turned into goals and objectives. To include the capacity needs in the strategic plan, an eighth priority area was developed.

The most recent version of the strategic plan is attached to this section. Next to each priority area is a description of the scope of activities that fall under that area and the goals and objectives developed thus far. Please note that the strategic plan is still in draft form and not all sections are complete. Many of the objectives are still being revised so that they fit into the SMART format. The plan is currently being reviewed within each of the FCHB sections to ensure

that all ongoing, planned and appropriate desired activities have been included and that the plan is still relevant given recent staff turnover and alterations in projects. The FCHB staff position(s) responsible for each objective and for the ongoing evaluation of that objective will also be determined in the section meetings or larger Bureau meetings. FCHB anticipates finalizing the strategic plan in the Fall of 2006, with periodic reviews and updates to occur after that point.

//2007//

/2008/ The most current version of the strategic plan is attached to this section. The strategic plan continues to be a working document assisting the FCHB in addressing the priority needs as identified with the 2005 Needs Assessment. The sections within FCHB have developed workplans based on the priorities, goals and objectives outlined in the Bureau strategic plan. The priority needs, which remained the same as in 2007, are as follows:

1) Environmental Health: It was determined that the Healthy Air Daycare data was not of a quality that could readily be adapted to creating a state performance measure. The Bureau's Oral Health Program is planning to strengthen their partnership with the Department of Environmental Quality with a goal of educating communities on their fluoride levels as a leveraging tool for increasing the numbers of schools participating in the fluoride mouth rinse program.

***2) Family support and education
NPM 2, NPM 3, NPM 5, NPM 6, NPM 8, NPM 10, NPM 11, NPM 15, NPM 16
SPM 1 (unintended pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)***

***3) Mental health and substance abuse
NPM 8, NPM 15, NPM 16
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 6 (abstaining from cigarette smoking during pregnancy)***

***4) Nutrition and obesity prevention
NPM 11, NPM 14***

***5) Promotion of preventive and accessible health care
NPM 1, NPM 2, NPM 3, NPM 4, NPM 5, NPM 6, NPM 7, NPM 9, NPM 12, NPM 13, NPM 17,
NPM 18
SPM 5 (Medicaid-eligible children who receive dental services)***

***6) Reproductive and sexual health
NPM 8, NPM 15, NPM 17, NPM 18
SPM 1 (unintended pregnancy)
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 6 (abstaining from cigarette smoking during pregnancy)
SPM 9 (public, middle and secondary schools that require comprehensive sexuality education as a part of their health curriculum)***

***7) Unintentional injuries
NPM 10
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)***

***8) Family and Community Health Bureau capacity development
The FCHB Section Managers and staff continued to review and refine the section work***

plans to insure that the activities and goals were represented and related to the Bureau strategic plan and that their objectives met the SMART (specific, measurable, achievable, realistic and time-bound) format. Subsequently, the Bureau plan's goals and activities were reviewed and modified as needed and accomplishments were noted throughout the past year. //2008//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------|-------|-------|-------|-------|
| Annual Performance Objective | 99.9 | 99.9 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 6 | 4 | 2 | 2 | 7 |
| Denominator | 6 | 4 | 2 | 2 | 7 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes - 2006

CZ

Notes - 2005

Two confirmed cases of PKU were referred for case management and primary care provider consultation to a contracted pediatric specialist of The Children's Hospital in Denver, Colorado. An additional initial positive PKU came from a postmortem test on a deceased newborn. No potential or confirmed cases of galactosemia occurred in 2005. Staff in the Children's Special Health Services section do direct follow-up with the contracted pediatric specialist for PKU and GALT positive results to ensure that appropriate consultation is provided for the affected baby's primary care physician and dietary management by the family.

Notes - 2004

Two cases of galactosemia were referred for case management by nurse consultants in Children's Special Health Services.

Mandatory tests in MT = PKU, Galactosemia, Congenital Hypothyroidism, hemoglobinopathies. Optional tests available = Cystic Fibrosis,

- Congenital Adrenal Hyperplasia , Biotinidase Deficiency* , Acylcarnitine Profile*
- Fatty Acid Oxidation Disorders
- § Medium Chain Acyl-CoA Dehydrogenase Deficiency
- § 3-Hydroxyacyl CoA Dehydrogenase Deficiency
- § Very Long Chain Acyl-CoA Dehydrogenase Deficiency
- § Short Chain Acyl-CoA Dehydrogenase Deficiency
- § Carnitine Palmitoyltransferase Deficiency

- § Glutaric Acidemia Type II
- § 2,4 Dienoyl-CoA Reductase Deficiency
- § Trifunctional Protein
- § Isobutyryl-CoA Dehydrogenase Deficiency
- § Short Chain Hydroxy Acyl-CoA Dehydrogenase Deficiency
- § Carnitine Translocase Deficiency
- § Carnitine Uptake Deficiency
- o Organic Acidemia Disorders
- § Glutaryl CoA Dehydrogenase Deficiency Type I
- § Propionyl CoA Carboxylase Deficiency
- § Methylmalonic Acidemia (mutase, Cbl A and Cbl B, Cbl C and Cbl D)
- § Isovaleryl CoA Dehydrogenase
- § 3-Methylcrotonyl CoA Carboxylase Deficiency
- § Mitochondrial Acetoacetyl CoA Thiolase Deficiency
- § 3-Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency
- § Malonic Acidemia
- § 3-Methylglutaconyl CoA Hydratase Deficiency
- § Medium Chain Hydroxy Acyl-CoA Dehydrogenase Deficiency
- § Medium Chain 3-Ketoacyl-CoA Thiolase Deficiency
- § 2-Methylbutyryl CoA Dehydrogenase Deficiency
- § Multiple Carboxylase Deficiency
- § 2-Methyl-3-Hydroxybutyryl CoA Dehydrogenase
- Aminoacidopathies* (tested by Tandem Mass Spectrometry - MS/MS) (CPT code: 82136, cost \$4.25)
- o Maple Syrup Urine Disease
- o Homocystinuria
- o Citrullinemia
- o Argininosuccinic Acidemia
- Tyrosinemia (type I, II, III)

a. Last Year's Accomplishments

In 2006, Montana's required panel of four tests (PKU, Galactosemia, congenital hypothyroidism, and hemoglobinopathies) was performed on 12,411 babies of the 12,463 live births in Montana (99.5%). Program staff in Children's Special Health Services (CSHS) section of the Family and Community Health Bureau worked with the Montana Public Health Laboratory staff and the primary care physicians to ensure monitoring for needed rescreening and referrals for special consultant services when necessary. CSHS staff made referrals to special health clinics for babies with confirmed conditions to ensure early intervention for the affected babies and their families.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Link newborn heelstick screening data with Montana birth certificates | | | | X |
| 2. Identify babies with Montana birth certificates who have no newborn screening data within two months of their birth and determine reason for no screening | | | X | |
| 3. Continue to ensure that all newborns with confirmed PKU or galactosemia conditions are referred to the contracted pediatric specialist for follow-up and primary care physician consultation | | X | | |
| 4. Contract with qualified consultants to perform followup services, including counseling and education, for children and parents of children identified withy metabolic or genetic disorders. | | X | | |

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b. Current Activities

The 2007 Montana State Legislature passed and the Governor signed Senate Bill 162 which expanded the newborn heelstick panel screening to the recommended national standard of 29 screens as endorsed by the American Academy of Pediatrics. SB 162 provides funds for contracted follow-up services for the expanded screening. The expanded screening will be implemented in January 2008 when the contracted follow-up services are also in place.

c. Plan for the Coming Year

The major plan for 2008 is implementing the expanded screening and contracted follow-up services. A Request for Proposal, in accordance with state requirements, will be developed in 2007 to secure the availability of the desired contracted follow-up services by January 1, 2008 for the expanded mandatory screening panel. Administrative Rules of Montana will be developed in accordance with state protocols to implement the expanded screening in 2008. Data on Montana births without mandatory screening (such as births by midwives who do not take the heelstick sample, unassisted home births and parental refusal at birthing facilities) will be monitored to identify educational outreach opportunities. Unassisted home births are not legally subject to the mandatory screening requirements. However, parental refusal may be the result of lack of information about the importance of screening and educational outreach may have an impact on reducing refusals. Likewise, educational outreach to midwives may increase the number of babies screened.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 0 | 54.2 | 54.5 | 55 | 55.3 |
| Annual Indicator | 54.0 | 54.0 | 54.0 | 54.0 | 54.0 |
| Numerator | 188 | 188 | 188 | 188 | 188 |
| Denominator | 348 | 348 | 348 | 348 | 348 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 55.6 | 55.6 | 55.6 | 55.6 | 55.6 |

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

A sample of parents representing multiple regional pediatric specialty clinics were surveyed at the

Regional Pediatric Specialty Clinics in Billings and Missoula. The surveys are not identical but represent parent satisfaction. All respondents reported a satisfaction rating of over 91%. Goal for 2006 is 93% with a standard survey tool developed by clinic site, CSHS, and parents.

Notes - 2004

Reporting on this performance measure is unchanged. Ongoing client satisfaction surveys are conducted at Pediatric Specialty Clinics. The Billings regional clinic site reports a 98.19% satisfaction rating on being involved in decisions and being listened to during clinic visits. This sample is small and therefore not representative of the cshcn population in general. This number will be modified in 2005 to represent a larger sampling of cshcn clients.

a. Last Year's Accomplishments

The Children's Special Healthcare Services (CSHS) Activity Plan was introduced to the Advisory Subcommittee in February 2006. The plan was used to monitor program activities and performance. The Advisory Subcommittee received semiannual updates at their meetings.

Two parents continued to actively participate on the CSHS Advisory Subcommittee along with healthcare providers, Clinic Coordinators, CSHS staff, and others. All members of the Subcommittee have equal roles as they plan program direction and discuss goals.

CSHS continued to collaborate and develop a strong working relationship with Parent's Let's Unite for Kids (PLUK). Projects they worked together on include the development of a statewide resource manual, universal metabolic screening issues, and the Universal Newborn Hearing Screening Task Force.

CSHS provided partial funding to a youth with muscular dystrophy and his family to attend the annual muscular dystrophy conference.

In parent surveys conducted at the Pediatric Regional clinics approximately 90% of parents gave favorable responses when asked about clinic conveniences, access, and parental involvement issues.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|---------------------------------|-----------|------------|-----------|
| | DHC | ES | PBS | IB |
| 1. Continued active parent participation in Children's Special Health Services (CSHS) advisory board. | | | | X |
| 2. Review comments from exit interviews for program modifications | | | | X |
| 3. Ongoing parent satisfaction survey's--Regional Pediatric Specialty Clinics. | | | | X |
| 4. Parent participation; Development of CSHS Activity Plan. | | | | X |
| 5. Partnership building with Parents Let's Unite for Kids (PLUK), parents and CSHS. | | | | X |
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b. Current Activities

Periodic PLUK and CSHS meetings promote a partnership for promoting and sustaining parental involvement.

CSHS parents attended the AMCHP Healthy Communities Seminar and a PKU conference in order to learn about national issues facing CSHS clients and new ways to manage PKU. A presentation from Family Voices, a national parent group prompted the book Bright Futures to be available at our clinics. Updates were given to the Advisory Subcommittee. Additional parent representation was added to the advisory subcommittee to give them more input in the future direction of CSHS.

A Pediatric Specialty Clinic survey was developed to rate parental satisfaction with services and gather suggestions for improvements. Initial results indicate an "overall great or good" score of 91% which was short of the goal of 93%. 93% will continue as goal as the survey is ongoing. CSHS conducts formal, one-to-one exit interviews at clinics allowing clients to provide feedback on their experience which is then shared with the healthcare providers. CSHS also gathers information about their medical home or lack thereof.

Through positive relationships with healthcare providers, CSHS works to limit expenses for their financially-challenged clients.

c. Plan for the Coming Year

The survey process at the regional pediatric specialty clinics will continue through December of 2008 with the data being used to improve quality of care.

CSHS will continue to promote parent participation by offering to sponsor parent attendance at workshops and seminars, and through expanded parental participation and utilization on the Advisory Subcommittee.

CSHS will continue to offer the Client-directed Flexible Cost Allocation Program which allows parents to elect how they want to spend their allocated funds related to the diagnosis and treatment plan that is covered by CSHS. Multidisciplinary teams at regional clinics encourage parental input in the treatment plan process.

Staff members will continue to work hard to include parents in the decision making process and negotiate with providers to reduce their medical costs. They will also seek input from children to participate with providers to encourage compliance with the treatment plan.

CSHS will work to promote consistency in all three regional pediatric clinic locations, plus standardize the exit interview process. The Nurse Consultant client/family treatment plan interview process will continue as this process provides an opportunity to discuss any treatment plan issues, i.e. barriers, as well as ensures that all questions and concerns were resolved for the client and his/her family.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | 52 | 52.2 | 60.2 | 52.6 |
| Annual Indicator | 51.7 | 51.7 | 51.7 | 51.7 | 51.7 |
| Numerator | 361 | 361 | 361 | 361 | 361 |

| | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|
| Denominator | 698 | 698 | 698 | 698 | 698 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 52.6 | 53 | 53.2 | 53.4 | 53.4 |

Notes - 2006

Notes - 2005

In 2004, number was calculated on 12.8% of population under age 18 x CSHS program data for CSHCN with medical home. For 2005 reporting, CSHS is maintaining the reporting of national survey data for continuity purposes. Program data on Primary Care Providers among the CSHCN population is reported in narrative section.

CSHS continues to emphasize coordination of care between pediatric specialty clinics and primary care providers. With the addition of the 3rd Regional Pediatric Specialty Clinic Site in 2006, this number is expected to grow. Continued education of primary care providers through staff attendance at the Montana Academy of Pediatrics annual meeting and other onsite visits are also expected to support this PM.

Following the MCHBG review, the targets for 2006 - 2010 were reset to more realistically reflect the data source being used.

Notes - 2004

Number is calculated on 12.8% of population under age 18 x CSHS program information for CSHCN with medical home.

With the continued focus on coordination of care within the medical home by programs such as Early Periodic Screening Diagnostic Treatment, this number is expected to continue to increase.

a. Last Year's Accomplishments

The 2005 Needs Assessment Survey identified the top five health needs for Montana's children with special health care needs (CSHCN). The top five issues identified were clinics to address special needs of children, access to dental care, access to health care, health insurance, safe and affordable child care/day care, respite care for parents and caregivers. The survey results provided important guidance for the Children Special Health Care Section (CSHS) and for healthcare providers, with an emphasis on addressing the difficulty accessing needed services. The importance of establishing a medical home, which plays a critical role for support, coordination, and education of the child's parent/caregiver, formed the basis for our work plan.

Medical home promotion activities were expanded in January of 2006 through the CSHS website which provided medical home links for providers and parents; success stories of individual children; and links to multiple community resources such as Parents Let's Unite for Kids (PLUK) and Montana School for the Deaf and Blind (MSDB). Clinic calendars are also available on the website which helped facilitate appointment scheduling for the families.

CSHS continued to support and provide consultation to the Follow the Child Project which uses public health home visiting teams to provide training to foster parents on the importance of the medical home concept, care follow-through and compliance with medical recommendations. The public health home visiting team also assisted in compiling the foster child's medical record, which included the child's medical history, as well as facilitated the coordination of the child's medical and mental health care.

CSHS continued to track client-specific Primary Care Provider (PCP) information using information from the CSHS financial assistance program and the Regional Pediatric Specialty Clinics. During visits to the multi-disciplinary specialty clinics, referrals were routinely made to PCP for follow-up care. On a FFY 2006 CSHS Client Satisfaction Survey, clients self-reported that an active PCP participated in the child's care 81% of the time. This percentage is somewhat different from what was reported within the Child Health Referral Information System's (CHRIS) self-reporting medical home survey.

CSHS Staff attended the Fall 2006 Montana Academy of Pediatrics meeting. The importance of issues such as the medical home concept, retail-based clinics, and reimbursement for immunizations was discussed. A CSHS Staff member participated on a Montana Pediatric Academy sub-committee related to service delivery, the need for corresponding required documentation, and the importance of adequate reimbursement.

CSHS Staff participated in monthly national telephone seminars, with an especially relevant seminar emphasizing the importance of communication among healthcare providers to maintain and support the child's medical home. CSHS Staff will use this awareness and important information as they work to build partnerships in the healthcare community and in their initiatives to promote the medical home concept.

CSHS contracted with Laura Nicholson MD, Developmental Pediatrician and Advisory Subcommittee Chair to educate peers about the medical home concept.

CSHS involvement with Medicaid Targeted Case Management was suspended during FFY 2006 due to Medicaid staff changes. The goals of targeted case management are being reviewed with the potential inclusion of a feasibility plan incorporating care management as a pilot project into the role of the Pediatric Specialty Clinic Coordinator.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. All regional pediatric specialty clinic participants are tracked and referred to medical home. | X | | | |
| 2. Analyze data from 2005 CSHCN needs assessment conducted in conjunction with CATCH Grant medical home project. | | | | X |
| 3. Children's Special Health Services (CSHS) web-site developed, including medical home links. | | | | X |
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b. Current Activities

CSHS subscribes to the AAP newsletter. Medical home issues and strategies to resolve participation obstacles are regularly featured articles, and are shared with the Clinic Coordinators. CSHS participates with the Montana Academy of Pediatrics (MAAP) subcommittee addressing issues: reimbursement rates and collaboration, how to manage logistics, and how to increase the number of children with a medical home.

CSHS is analyzing numerous data sources of the occurrence of a medical home. The analysis will direct future activity aimed at increasing the number of children with a medical home.

The Clinic Coordinators continue to be directly responsible to ensure that each child's treatment plan accurately reflects the clinic's multi-disciplinary professional team's recommendations, as well as those of the subspecialty physicians and that the treatment plan is shared with the PCP, and other participating healthcare providers.

CSHS extended their collaboration with Laura Nicholson, MD, Developmental Pediatrician and Advisory Subcommittee Chair. Dr. Nicholson provides project planning advice, which includes identifying solutions related to the medical home concept, as well as continuing to promote the medical home concept within the pediatric community.

A previous goal for a social worker/nurse to facilitate coordination of care for CSHS in a pediatric office did not align with our regionalization strategic plan; therefore, no efforts were expended on this goal.

c. Plan for the Coming Year

CSHS plans to maintain their Medicaid and CHIP relationship through strategic planning activities, with a goal of identifying ways to provide reimbursement to providers who spend additional time with special needs children, who require extra coordination, planning, and follow-up services.

Additional Medicaid discussion topics include the specialty care reimbursement rates, with the CSHS Advisory Subcommittee members providing documentation and data; and a potential collaboration concerning proposed retail clinics and the need for these clinics to provide comprehensive care for CSHCN.

CSHS plans to continue the relationship Laura Nicholson, MD, providing support and direction as needed.

CSHS plans to web-enable the portion of the CHRIS software application allowing providers to make electronic client referrals of new and existing clients for clinic evaluations and follow-up care, as well as access to clinic schedules in "real time." The electronic referral process will facilitate timely contact and follow-up with families and other providers.

CSHS will serve on a Montana Academy of Pediatrics subcommittee that is charged with the task of identifying ways to improve the availability of the medical home to each CSHCN. A key focus will be to continue advocating for client-centered care in which the family and the child play an active role in developing treatment plans and follow-through activities. Improved reimbursement to providers who serve as the medical home is an additional priority issue.

CSHS will provide training and technical assistance to the individuals involved in the CHRIS data collection and entry so as to ensure that medical home data is of high quality and accurate; thus ensuring the accuracy of future reports. The medical home data will also be used in determining areas of additional promotion.

CSHS will continue efforts to contract through hospitals to pay for case management. The case manager's role is critical in identifying children who do not have a medical home and facilitating the process. The case manager is equally critical in maintaining the medical home for children who meet the criteria in order to provide ongoing coordination and support to both the family and the primary care provider.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 0 | 50 | 50.3 | 78.5 | 50.4 |
| Annual Indicator | 48.8 | 48.8 | 48.8 | 48.8 | 48.8 |
| Numerator | 350 | 350 | 350 | 350 | 350 |
| Denominator | 717 | 717 | 717 | 717 | 717 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 50.5 | 50.6 | 50.7 | 50.8 | 50.8 |

Notes - 2005

These data are from the National CSHCN Survey results. Verification of specific benefit plan coverage is not addressed. Children's Special Health Services (CSHS) continues to work to improve adequacy of coverage through partnerships with Montana Medicaid, CHIP, and other insurance companies.

MCHBG reviewers noted the 78.5 target was very high. Note subsequent year targets had been made prior to initial MCHBG submission.

Notes - 2004

The data are from the National CSHCN Survey results.

a. Last Year's Accomplishments

In 2006, CSHS provided services to a total of 3773 children through the Regional Pediatric Specialty Clinics and continued to assess their clients' health care coverage status. At the Clinics, clients were referred for financial assistance or were given information about other payee sources, such as CHIP or Medicaid. CHIP referred 455 children to the CSHCN program.

CSHS continued to partner with CHIP to provide funding for services not covered for the CHIP population and to increase awareness of CSHCN coverage needs. Specific needs can include reimbursement for hearing aids, orthodontia related to our clinic treatment plan, or coordination of services for other public and private resources.

CSHS continued to provide limited financial assistance for specialty care to qualifying uninsured and underinsured families who were at or below 200% of poverty. These families' medical bills were paid directly by CSHS and in FFY 2006 a total of \$105,072.00 was spent on 100 children.

CSHS continued to partner with Developmental Disability Services to provide SSI applicants with resource and referral information.

A presentation was made to Blue Cross/ Blue Shield of Montana to educate third-party payers about cleft/craniofacial disorders and to establish the critical role of multi-disciplinary teams in the standard of care for a coordinated treatment plan.

CSHS continued to implement policies allowing families to determine how to spend their allocated assistance for the benefit year. The policies encouraged families to be self determining in managing their child's health care dollars and encouraged increased parent participation.

A CSHS dedicated staff member continues to provide care coordination and support for clients and their families as they navigate and negotiate the health care system.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continued limited financial assistance for medical services. | X | | | |
| 2. Continued partnership with Medicaid program regarding specialty services in Montana. | | | | X |
| 3. Ongoing shared referrals with CHIP. | | X | | |
| 4. Explore electronic link between Children's Special Health Services (CSHS) and CHIP. | | | | X |
| 5. CSHS established provider status with Medicaid and CHIP for multidisciplinary team clinics. | | X | | |
| 6. Continue to partner with Medicaid and CHIP for approval of payment for orthodontic care for CSHCN with craniofacial conditions. | | X | | |
| 7. Provide information to CHIP and other insurance regarding coverage needs of CSHCN. | | | | X |
| 8. | | | | |
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| 10. | | | | |

b. Current Activities

The past four years have seen a decline in the general population covered by public or private health insurance; (Dr. Steve Seninger, Director of Montana Kids Count, November 2006) Montana DPHHS requested and supported SB 22 legislation expanding the Children's Health Insurance Program (CHIP) from 150% to 175% of poverty. The anticipated impact, as of July 1, 2007, is for an additional 2,100 children to be on CHIP, for a total enrollment of approximately 16,000 children.

CSHS collaborated with private insurers to develop favorable policy interpretation for children with special health care needs which resulted in maximizing CSHCN's benefits. CSHS implemented a process to bill insurance companies for multi-disciplinary clinics. This innovation has generated revenue which augments CSHS's efforts to support subspecialty clinics, and explore expanded transition services, and additional claims assistance.

Parent requests for hearing aids prompted CSHS' input for legislation for coverage by public and private insurance policies. The legislative attempt to enact this change was unsuccessful.

CSHCN families completed a financial needs assessment and received information about potential assistance, referrals to Supplemental Security Income (SSI), Medicaid, CHIP, and other diagnosis-related resources.

A previous goal for regional clinics to assume the billing responsibility was determined to be inappropriate at this time, although this goal may be revisited at a future date.

c. Plan for the Coming Year

CSHS will continue to educate families regarding health coverage options such as CHIP, Medicaid, and private insurance.

CSHS will educate and train Clinic Coordinators about the practical aspects of private insurance, such as prior authorization, waiting periods, and pre-existing exclusions. Coordinators who are well versed in health coverage procedures and policies will be better able to assist the team and families in making decisions that maximize available treatment and minimize costs.

CSHS will begin discussions with Medicaid regarding reimbursement issues for specialty care. CSHS Advisory Subcommittee members will collaborate in this process by providing documentation and data.

CSHS will provide documentation and data to support the Montana Academy of Pediatrics' efforts to obtain Medicaid reimbursement for specialty care. Improving reimbursement could be a key factor in creating incentives for providers to increase their participation in providing care to special needs children, including serving as the medical home. CSHS Advisory Subcommittee members will actively collaborate in this process.

CSHS will continue to work closely with in-state and out-of-state providers to negotiate for best-value services for our clients.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 0 | 71.9 | 72.2 | 72.4 | 72.6 |
| Annual Indicator | 71.6 | 71.6 | 71.6 | 71.6 | 71.6 |
| Numerator | 250 | 250 | 250 | 250 | 250 |
| Denominator | 349 | 349 | 349 | 349 | 349 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 72.8 | 72.8 | 72.8 | 72.9 | 72.9 |

Notes - 2005

For 2005 reporting, CSHS is maintaining the reporting of national survey data for continuity purposes.

Initial steps in the development of the 3rd Regional Pediatric Specialty Clinic were taken. Funding to contract with a community provider was available January of 2006. This 3rd site will provide regional access across Montana, thus assuring families of easier access to special care and coordination of follow-up at the community level. Standardized parent satisfaction surveys will be developed and conducted at this site.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Tobacco tax funding for a third regional clinic site was approved by the Montana legislature in 2005. The funding became available January 2006 and an RFP was submitted to interested parties January 30, 2006. CSHS contracted in April 2006 with the Great Falls Clinic to provide the North Central Regional Pediatric Site. The Clinic Coordinator was hired in June 2006. Initial clinic visits began in June of 2006, with formal coordinator orientation in July of 2006. The Central Montana location is strategic in providing access for a large special needs population. In the initial first quarter there were 91 visits.

Children's Special Health Service, CSHS, was established as a Medicaid and CHIP provider and submitted claims for services provided to clients through the cleft/craniofacial and metabolic clinics. The revenue was used to maintain and expand clinic services.

The additional revenue also allowed CSHS to reimburse subspecialty providers and to continue to contract with out of state providers to travel to Montana to help address the access issue for children living in rural areas.

CSHS continued to develop the functionality of the Children's Health and Referral Information System (CHRIS) software application and database, enabling other service programs to coordinate care by using CHRIS as a case management tool. The Montana School for the Deaf and Blind developed a partnership with CSHS by linking through CHRIS for these services. In addition, using the mailing functionality in the CHRIS system resulted in less staff time being expended on mass mailing projects, such as sending out HUFF 'N PUFF asthma camp brochures to CSHS clients included in the CHRIS database.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Ongoing financial support, training and consultation for Regional Pediatric Clinic Sites. | | | | X |
| 2. 3rd Regional Pediatric Clinic Site (to complete regional clinic coverage) developed. | | | X | X |
| 3. Develop electronic link with Montana School for the Deaf and Blind (MSDB) to facilitate tracking/shared services for hearing and vision impaired infants, children, and youth. | | | | X |
| 4. Revising cleft/craniofacial documentation to standardize and facilitate reporting. | | | X | |
| 5. Partnership with Parents Lets Unite for Kids (PLUK) for resource manual for parents. | | | | X |
| 6. Spend clinic billing money to support Regional Pediatric Specialty Clinic Sites. | | | | X |
| 7. Develop pilot project for Medicaid Targeted Case Management (TCM) for CSHCN, including developing a working definition of a pilot and establishing clinical TCM providers. | | | | X |
| 8. | | | | |
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b. Current Activities

CSHS sponsored a nutritionist to attend Utah Leadership Education in Neurodevelopmental Disabilities Regional Program (ULEND). This nutritionist will provide specialized training to other

nutritionists at Metabolic Clinics.

Results from the Specialty Clinic Family Surveys rated overall clinic services as 91% or good/positive. The survey results also indicated that Specialty Clinics were held "the right amount of times" (75%) versus 8% "not often enough." The non-response rate for both questions was 8%..

Families requested a regional clinic to decrease travel time and expenses. The Helena's South Central Metabolic Clinic was transferred to Regional Pediatric Specialty Clinic in Great Falls. Development of this clinic was a priority over expanding the existing clinics.

The number of parent representatives to our CSHS Advisory Subcommittee increased from 2 to 3 parents, 3 clinic coordinators, 7 pediatric physicians, an early intervention specialist, for a total of fourteen. Parents provide an important community link; their experiences guide our action plan and they advocate for change to serve the CSHCN.

CSHS is actively participating in the Joint Committee for Healthy Kids and Montana Rural Institute Seminar web casts. These groups work to provide networking, update current information about available programs within the state, and address the needs of our Native American population. CSHS also continues to partner with a parent to parent support group, (PLUK).

c. Plan for the Coming Year

CSHS will continue to work and partner with state organizations such as Medicaid and CHIP, as well as with community based organizations such as PLUK, in order to share information, collaborate, and to educate one another. The goals will continue to be on developing child and family focused programs and partnerships.

CSHS will continue to evaluate the services they provide while keeping in mind the unique needs of the clients they serve.

CSHS plans to maintain its current web site, CHRIS, in order to provide up to date information and links to other sites which its clients may find useful. The creation of a provider website with information about specialty clinics is also planned.

CSHS plans to partner with Indian Health Services in order to develop a care coordination plan which advocates for children by providing culturally sensitive parent education.

CSHS will continue to work to promote awareness of our program and the services we provide.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | 6 | 6.5 | 6 | 6 |
| Annual Indicator | 5.4 | 5.4 | 5.4 | 5.4 | 5.4 |
| Numerator | 8 | 8 | 8 | 8 | 8 |
| Denominator | 147 | 147 | 147 | 147 | 147 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and | | | | | |

| | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|
| 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 6.5 | 6.5 | 7 | 7 | 7 |

Notes - 2005

No change has been made in the data from previous year.

Transition issues are addressed for all youth aging out of Regional Pediatric Specialty Clinics services and CSHS addresses transition of health care for youth aging out of the CSHS financial assistance program.

During the 2004-2005 school year 944 students graduated from regular high school with an active IEP, which is required to contain transition information. The degree of health transition information included in IEP's is undefined. CSHS plans to work with OPI and other community and state agencies to determine how best to participate in inclusive transition planning.

Targets reviewed - no change made.

Notes - 2004

No change has been made in the data from the previous year.

The TA was requested. Transition issues are continually discussed on a provider to family basis regarding the appropriate developmental stages. CSHS has established a collaborative relationship with the Office of Public Instruction and Vocational Rehabilitation with a goal of exploring how this information might be obtained and how to improve transition services.

a. Last Year's Accomplishments

A Supervisor was hired in June 06 to provide direction and oversight for the Children's Special Healthcare Services (CSHS) Section.

Results from screenings done at Regional Pediatric Clinics were reviewed by CSHS staff and clinic coordinators to identify issues faced by patients transitioning into adult services and to provide assistance and referrals as necessary.

CSHS met with the Office of Public Instruction to review their Individualized Education Plan (IEP) format and related transition plan for education. Their education transition plan did not focus on the medical home issues. Extensive research and review of existing literature was assigned to staff. Clinic Coordinators discussed findings at monthly meetings.

CSHS and Parents Lets Unite for Kids (PLUK) worked together to develop a resource manual listing community and clinical resources available to help with transitioning issues.

A feasibility study was planned for FFY 06 to explore the fiscal impact of increasing the age limit for financial assistance to age 22 for CSHCN with chronic conditions. Our internal strategic plan did not identify this as a top priority.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions . | | X | | |

| | | | | |
|---|--|--|--|---|
| 2. Offer financial support and information to pre-teens and teens for peer educational opportunities. | | | | X |
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b. Current Activities

CSHS participates on Family Support Advisory Subcommittee, Joint Committee for Healthy Kids, Rural Institute Training Sessions /University of Montana, and Catalyst Center Topical Conference Call Series addressing transition issues. CSHS attended meetings of the Mountain States Genetics Regional Collaborative Center and the Montana Children's System of Care Conference that also address the transition process.

An identified barrier to health care transition in Montana is obtaining a medical home with an appropriate treatment plan that is acceptable to both parents and the young adult client.

CSHS offered to sponsor three clients to attend out of state metabolic camp that promoted transitional planning. The dates conflicted with local schedules.

After reviewing literature from the University of Washington, Cystic Fibrosis Foundation, the Casey Family Program, and others, CSHS discussed transitioning tools with the Clinic Coordinators. The Advisory Subcommittee in June 2007 will review the literature and make recommendations.

c. Plan for the Coming Year

CSHS and Clinic Coordinators plan to begin offering Metabolic camp scholarships to teenagers earlier in the year in hopes of increasing attendance. Information from attendees about what they learned regarding transition issues will be used to evaluate this part of the program.

With input from the Advisory Subcommittee which includes 7 pediatric physicians, 3 clinic coordinators, and three parents, CSHS will adopt or develop a transitional care questionnaire for our clinics. This questionnaire will focus on the medical aspect of the transition from childhood to adulthood, including managing the medical condition, obtaining health coverage and services, and follow through with the treatment plan.

CSHS will review data from the transitional care questionnaire to examine the feasibility of offering social services, or financial assistance during this transition period.

CSHS will continue to foster direct communication between the client and health care provider to ensure that young adults are involved in the decision-making process, ensuring compliance with the treatment plan for a positive outcome.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 90 | 90 | 90 | 91 | 80 |
| Annual Indicator | 90.7 | 89.7 | 90.9 | 91.9 | 73.8 |
| Numerator | 2610 | 2440 | 2603 | 2568 | 12013 |
| Denominator | 2878 | 2721 | 2864 | 2793 | 16279 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 80 | 80 | 80 | 80 | 80 |

Notes - 2006

The source of data is the National Immunization Survey (NIS) (http://www.cdc.gov/vaccines/stats-surv/nis/tables/0506/tab03_antigen_state.xls). Please note that the 95% confidence interval for this indicator is +/- 6.3. The numerator and denominator are estimates based on the NIS report of 73.8% of MT children 19 to 35 months with appropriate vaccination coverage. The denominator is pulled from the estimated population of MT children listed in the NIS 2005 User's Guide.

A survey of providers indicates that vaccination rates among children who are able to access a provider (the data source in previous year) remain high, around 90%. The data source was changed to the NIS this year to be in closer compliance with the MCHBG guidance.

An electronic immunization registry was established in Montana several years ago. Participation in the registry has been gradually increasing since its inception. 2006 registry data reported 7145 children who have completed their immunization schedule by the end of their second year. Using an census estimate of 11692 two year olds in the state, this provides an indicator of 61.1%. However, not all providers participate in the registry and not all IHS sites are reporting. We expect the indicator from this source will increase as reporting improves. In the meantime we will use the NIS as the source of data. cz, df

Notes - 2005

The data for this performance measure are collected using an immunization survey, which samples public and private immunization providers throughout the state. The data were collected from 53 of the 56 counties, including Tribal and IHS clinics, and represent 25% of the birth cohort. The survey only collects data on children ages 24-35 months. The policy of the Montana immunization program is to only consider children to be late in receiving all age-appropriate vaccinations when they have reached 24 months. While they do evaluate coverage at 19 months, they only assess actual coverage and lack of coverage among 24 month-olds and older.

The state recently implemented an electronic immunization registry. This registry is expected to provide population-level data on Montana's immunization rates within the next several years as reporting improves and links with vital statistics data are developed.

The numerator represents the number of children assessed by the survey who were appropriately immunized. The denominator represents the number of children assessed.

The immunization rate refers to the series combination of 4 DTaP: 3 Polio: 3 Hib: 1 MMR: 3 Hep B. For 2005, the 4:3:3:1:3 rate was 91.9%, exceeding our objective.

During the next year, varicella will be added to the required vaccine regimen. Because of this change, the immunization rate is expected to drop, then gradually increase as varicella vaccination rates increase.

a. Last Year's Accomplishments

The roll out to private providers during the summer of 2006 gave 70 private provider sites view only access to the statewide registry system. Roll out in several local counties involved school nurses as well.

Reading Well collaborative project with Medicaid and the Office of Public Instruction continued during 2006. (This was well described in last year's report).

In September of 2006, the daycare rule requiring proof of receiving a dose of varicella vaccine for children between the ages of 12 -- 19 months of age in the daycare facilities was implemented.

Varicella became a reportable disease by case. Reporting formats were developed and education will be provided in an on-going plan. Since the reporting of varicella disease does not require lab confirmation, county health departments have had to develop systems for case base reporting.

The baseline year for the 2nd MMR prior to kindergarten entry was 2004 at 81.43%. For the 2006-2007 school year, the immunization rate for MMR 2nd dose was 98.4%. The number of schools surveyed was 445 with 11,420 children out of a total 449 kindergartens with 11,536 children. Twenty-nine or 0.25% of the kindergarten children were exempted from one or more required vaccine for medical reasons. One hundred fifty-four or 1.35% of the kindergarten children had religious exemptions from one or more required vaccines.

In the fall of 2006, the administrative rule requiring proof of receiving a booster dose of Tdap/Td prior to entry to grade 7 was implemented. The rule was passed in summer of 2005, but implementation for grade 7 was held up to allow for the new Tdap vaccine that was just reaching the market in 2005. The compliance will be monitored during the fall of 2007 to evaluate Tdap/Td rates of children grade 7. For comparison, the baseline established in 2006 for a Tdap/Td booster was 76.4%. Of the total 328 middle schools in Montana with 11,443 children, 325 with 11,168 were surveyed. Of those surveyed, 8,536 or 76.4% had received a Tdap or Td booster.

Eighty-eight or 0.79% of the grade 7 children were medically exempt from one or more required vaccines and 132 or 1.18% had religious exemptions.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Contract with county health departments for maintenance of statewide immunization registry. | | | X | |
| 2. Distribute VFC vaccines to providers registered with the Vaccines for Children Program in Montana from 54 counties and 7 tribal health jurisdictions. | | | X | |
| 3. Contract with the county health departments to assess immunization records of children in the day care settings. | | | X | |
| 4. Contract with the county health departments to assess the school immunization record of kindergarten students and grade 7 students. | | | X | |
| 5. Contract with the county health departments to provide educational services to staff in private clinics in their health jurisdictions regarding immunization. | | | X | |

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b. Current Activities

The electronic import of records from the birth registry into the Web-base Immunization Registry Database (WIZRD) is currently in the test phase. When this project is in production, all birth doses of hepatitis B vaccine given in the hospitals to newborns will be recorded in the electronic registry, if approved by the parents. An educational module will be developed to assist the local health departments to provide education to the hospital staff, which will provide the education about the benefit of having the immunization doses recorded in the electronic registry.

The electronic import of immunization records from the Indian Health Service (IHS) is close to moving to production. The records will be shared with IHS to the statewide immunization registry once per week.

All Vaccine for Children (VFC) providers will be visited again in 2007. Problems with vaccine storage, handling and delivery will be addressed as they are identified. Deficiencies will require correction.

HPV vaccine will be made available for young women ages 19 -- 26 that are seen in Tribal and IHS clinics in a pilot study during 2007 to determine the demand for the HPV vaccine in age cohorts outside the VFC age categories.

c. Plan for the Coming Year

1) Improve varicella surveillance in local health jurisdictions through education of the professional health care providers.

2) Varicella immunization status in the daycares will be reported by the county health departments as a requirement of their contract obligations.

3) Varicella immunization status for children 24 -- 35 months of age will be reported by the health education specialists following the clinic reviews in each clinic and office during 2007.

4) Tdap/Td booster rates for children in grade 7 will be reported and compared to the baseline rate in 2006.

5) Education regarding importance of HPV vaccine will be discussed in the Department, and in the Cervical Cancer Task Force meetings. Materials for education of the public will be developed and distributed

6) Continue providing professional education for the public and private vaccine providers during the regional immunization workshops.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 19 | 18.5 | 18 | 15 | 9.6 |
| Annual Indicator | 17.4 | 15.4 | 17.3 | 17.0 | 17.5 |
| Numerator | 373 | 330 | 349 | 347 | 355 |
| Denominator | 21378 | 21378 | 20144 | 20392 | 20238 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 17 | 17 | 17 | 17 | 17 |

Notes - 2006

Numerator data includes births to resident teens ages 15-17 from vital records. Denominator data is census estimates for 15-17 year old girls in Montana in 2006. The objective for 2006 was determined based on data reported in previous years that made the indicator appear lower than it actually was. Previous years' data were corrected in 2006 with final data. The numerator was updated with final 2006 vital statistics data. df

Notes - 2005

Numerator data includes births to resident teens ages 15-17. Denominator data came from the 2005 estimates for 15 to 17 year old girls in Montana. Denominator was updated in 2006.

Notes - 2004

Numerator data includes births to resident teens ages 15-17. Denominator data came from the 2004 Census estimates for 15 to 17 year old girls in Montana. Denominator was updated in 2006.

a. Last Year's Accomplishments

The Montana Department of Public Health and Human Services (DPHHS) includes the prevention of teen pregnancy as one of its key issues in public health. The Women's and Men's Health Section (WMHS) fills a leadership role in teen pregnancy prevention efforts for the Department. The WMHS Health Educator acts as the Department's Teen Pregnancy Prevention Coordinator.

The WMHS is currently exploring new ways to integrate teen pregnancy prevention efforts into its program and the Department. Strategies under consideration include participating in The National Campaign to Prevent Teen Pregnancy's "Setting Teen Pregnancy Rates Reduction Goals" -- a national effort to set the teen pregnancy prevention agenda for the next decade and create a statewide teen pregnancy prevention coalition.

The WMHS Program Specialist acts as a key resource for the collection and dissemination of teen pregnancy data. The Trends in Montana Teen Pregnancies and Their Outcomes From 1981 - 2000 report is in the process of being updated. The updated tables are available to be distributed to local family planning clinics, county health department personnel, media contacts, public policy makers, and university students. Recent analyzed 2005 data shows that the teen pregnancy rate continues to drop for 15-19 year olds and is currently 47.8/1,000. This represents a 21.8% reduction from the 1995 rate of 61.2/1,000.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. In State Fiscal Year (SFY) 2008, contract with 15 agencies with services in 29 clinic sites for reproductive health care, including funding for high-cost contraceptives. | | | | X |
| 2. In SFY 2008, at least 28% of FP clients served by local clinics will be 19 year and under. | X | | | |
| 3. In SFY 2008, 100% of local clinics will outreach to youth at high risk of teen pregnancy and birth. | | | X | |
| 4. In SFY 2008, the FP Education Committee will assess and coordinate training as needed for local clinic staff through a minimum of 8 conference calls. | | | | X |
| 5. | | | | |
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b. Current Activities

The WMHS contracts with 15 agencies to provide reproductive health care. Almost one-third of clients served in SFY 2007 were teenagers and outreach is conducted to teens because they are considered at high risk for teen pregnancy and birth. In order to better serve the teen population and reduce the risk of unintended pregnancy and teen births, the WMHS Education Committee assesses and coordinates training as needed for local clinic staff.

WMHS is in the process of updating its "Trends in Teen Pregnancy Report," last updated in 2002. Once completed, the "Trends in Teen Pregnancy Report" will be distributed to local partners focusing on teen pregnancy and teen birth rates, including local health departments, Women, Infants and Children (WIC) agencies, Offices of Public Assistance, school districts, Public Health Home Visiting projects, Indian Health Service clinics, media contacts and public policy makers.

Special funds were received during State Fiscal Year (SFY) 2007 to serve high-risk and targeted populations--such as teens. The WMHS applied for and received special grant funding for male services, satellite clinics and high-cost.

Annually, the health education specialist organizes a statewide campaign in May for Teen Pregnancy Prevention Month. Outreach packets including a press release, sample letters to the editor, posters, and educational brochures are distributed to all family planning clinics.

c. Plan for the Coming Year

The WMHS will facilitate community acceptance of and access to family planning services and counseling for clients of all ages. The WMHS will contract with 15 agencies to provide family planning services in 29 locations in Montana. In working toward this goal, the WMHS will continue to assure the active and continued involvement of family and community in the provision of family planning services to those in need.

Local clinic staff will continue to participate in the State Family Planning Education Committee (SFPEC) facilitated by the WMHS Health Educator. The SFPEC has identified Teen Pregnancy Prevention Month as a priority and will continue to coordinate a statewide outreach campaign. In order to improve the effectiveness and breadth of the message, the SFPEC is looking at ways to involve more teens in the campaign planning process.

WMH is assessing the potential for a statewide adolescent health taskforce, missioned to reduce teen pregnancies as well as teen suicide and other high-risk behaviors.

The WMHS will apply for strategic initiative funding in SFY 2008 that supports targeted projects to expand services in underserved communities, as well as to improve community teen pregnancy prevention partnerships. Each of the projects will address the HP 2010 goal to reduce the rate of unintended pregnancy, and to reduce pregnancies among adolescent females.

The WMHS will continue to provide special funding for contraceptives to local family planning clinics.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 40 | 41 | 42 | 40 | 40 |
| Annual Indicator | 5.2 | 13.0 | 41.6 | 33.2 | 45.9 |
| Numerator | 668 | 1683 | 4283 | 3413 | 4693 |
| Denominator | 12907 | 12907 | 10295 | 10295 | 10225 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 40 | 40 | 40 | 40 | 40 |

Notes - 2006

Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2005-2006 school year, from the Montana Office of Public Instruction. df

Notes - 2005

For 2004 estimates, oral health convenience data was utilized. Prior to 2004, estimates were derived from Medicaid data only. For 2005 estimates, a random oral health sample was collected. Data percentages extracted from the random sample were utilized to extrapolate the numerator applicable for this measurement, as the random sample was only a proportion of the target population.

Notes - 2004

Sealant assessment for 2004 was evaluated via convenience sampling of volunteer schools throughout the state. The rate is calculated using a crude prevalence with weights calculated and applied based on regional 3rd grader population totals obtained from the Office of Public Instruction (OPI). However, when the data was regionally stratified and weights were applied by region, 2004 weighted data contained an outlying region over two standard deviations from the mean, causing significant skewness of the results (with over a 10% difference). Therefore, the

calculation reported here contains only 4 regions, as the outlier region was purposefully extracted from the dataset.

a. Last Year's Accomplishments

The State of Montana contracted with a MCH Epidemiologist to prepare the 2005-2006 statewide stratified, random sample oral health data report. This report entitled "Montana: 2005-2006 Study of Oral Health Needs: 3rd Graders and Head Start Children" was received June of 2007. The report suggested that with additional delineation by free or reduced lunch strata, significant access to dental care issues may be present for Montana's underprivileged children. When 95% confidence intervals were calculated, children in schools classified as a free or reduced lunch school had significantly higher rates of untreated cavities, carries experience, and urgent treatment needs. These children were also significantly less likely to be assessed by the visiting hygienist as cases who receive routinely scheduled care. The sealant placement prevalence rate for children in schools classified as a free or reduced lunch school was not statistically significant from the children in the non-free reduced lunch schools, although the rate was slightly lower among free or reduced lunch school children.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue to monitor 3rd grader sealants in the public school system through the volunteer-only convenience sample | | | X | X |
| 2. Promote and disseminate information to schools and other stakeholders as to the benefits of sealants by age 8 (3rd grade). | | | X | X |
| 3. The MOHA will utilize the report "Montana: 2005-2006 study of Oral Health Needs: 3rd Graders and Head Start Children" to develop strategies to increase sealant placement | | X | X | X |
| 4. | | | | |
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| 10. | | | | |

b. Current Activities

Information from this report "Montana: 2005-2006 Study of Oral Health Needs: 3rd Graders and Head Start Children" is currently being analyzed. Data was utilized for Montana's application of the Targeted State MCH Oral Health Service Systems Grant funding, MCHBG reporting, and preparation of MT's Oral Health Strategic Plan by members of the Montana Oral Health Alliance (MOHA), which resumed meeting in FFY 2007. Final report statements will be prepared and distributed to key oral health stakeholders in Montana in the Fall of 2007.

c. Plan for the Coming Year

The MOHA will utilize the report "Montana: 2005-2006 Study of Oral Health Needs: 3rd Graders and Head Start Children" to develop strategies to increase sealant placement on Montana's 3rd grade students, over the next five years.

Pending receipt of the Targeted State MCH Oral Health Service Systems Grant funding, Community Health Center/Dental Clinics (CHC/DC) will be afforded the opportunity to increase their capacity of providing evidenced based preventative activities, which includes 3rd grade students receiving sealants, with a focus on Medicaid and CHIP eligible children. Ongoing data collection from the CHC/DCs will assist in developing additional funding strategies that support the MOHA's strategic plan.

The Montana statewide awareness campaign, under the direction of the MOHA, will include information about evidence-based, best practice, preventative methods, such as the effectiveness of a sealant delivery program.

Continue to monitor 3rd grader sealants in the public school system through the volunteer-only convenience sample.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 4.8 | 4.7 | 4.6 | 4.5 | 4.4 |
| Annual Indicator | 5.4 | 4.3 | 5.6 | 5.7 | 5.1 |
| Numerator | 10 | 8 | 10 | 10 | 9 |
| Denominator | 186130 | 186130 | 178212 | 176874 | 176378 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 4.3 | 4.2 | 4.1 | 4 | 4 |

Notes - 2006

Denominator data are from the July 1, 2006 census estimates for the population of 0-14 year olds in Montana (released in 2007). Numerator data are from final vital statistics data for 2006. df

Notes - 2005

Denominator were updated in 2007 to reflect the most recent census estimates for the number of children ages 0 to 14 years of age in Montana. Numerator data came from vital stats.

Despite the disparity between the indicator and objective, Montana is retaining the aggressive objective for this PM.

Notes - 2004

Denominator were updated in 2007 to reflect the most recent census estimates for the number of children ages 0 to 14 years of age in Montana. Numerator data came from vital stats.

a. Last Year's Accomplishments

The Child, Adolescent and Community Health (CACH) Section of the Montana Department of Public Health and Human Services (DPHHS) continued to act as a team member on the ambulance/emergency room/payment feasibility data linkage project.

The Adolescent Health Consultant continued participation on the State Fetal Infant Child Mortality Review (FICMR) team.

CACH staff participated on the Emergency Medical Services and Trauma Systems (EMS) Advisory Committee as well as the Injury Prevention Sub-Committee in order to collaborate

efforts in reducing the number child fatal and non-fatal motor vehicle crashes.

CACH staff provided an educational press release on the Graduated Drivers License Law which went into effect July, 2006

The 2003-2004 FICMR data report was completed in 2006. The report included an assessment of preventable deaths and community level interventions

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Child, Adolescent and Community Health (CACH) section staff will continue to advocate legislative efforts to decrease motor vehicle deaths by supporting the primary seatbelt law (which establishes not wearing a seatbelt as a primary offense) | | | | X |
| 2. CACH staff will support stronger legislation on driving under the influence (DUI) through research and analysis of data relating to death and injury from motor vehicle crashes involving alcohol. | | | | X |
| 3. The Adolescent Health Coordinator will work with the Joint Committee for Healthy Kids, Connecting for Kids and the State Fetal, Infant and Child Mortality Review (FICMR) team to research strategies for further reducing alcohol-impaired driving | | | | X |
| 4. CACH staff will research and promote social marketing techniques to educate opinion leaders and the public about the causes of motor vehicle-related injuries and effective personal safety practices. | | | X | |
| 5. The FICMR Coordinator will continue the collection, analysis, and dissemination to partners and the public of FICMR data relating to motor vehicle crashes. | | | X | |
| 6. Continue Partnership with Healthy Mothers Healthy Babies non profit organization for car seat safety education and resource information. | | | X | |
| 7. | | | | |
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b. Current Activities

CACH supports legislative efforts to improve safety by advocating for primary seatbelt laws, and by pursuing stronger legislation regarding driving under the influence of drugs and alcohol

FCHB staff provided information for testimony before the 2007 Legislature in favor of a primary seat belt law

CACH staff is working with the Joint Committee for Healthy Kids (JCHK), Connecting for Kids, and State FICMR team to research strategies for reducing alcohol-impaired driving

CACH staff attends EMS Advisory Committee meetings and Injury Prevention Sub-committee meetings to collaborate efforts to reduce the number of child and adolescent motor vehicle deaths

CACH staff provided information for a press release from Department of Transportation (DOT) on

parental seat belt use

The FICMR Coordinator is exploring and promoting social marketing techniques to educate leaders and the public about the risk factors in vehicle-related injuries and mortalities to effect personal safety practices

The February FICMR State Team meeting focused on motor vehicle crash (MVC) deaths. As a result FICMR has become involved in a collaborative effort with DOT, Office of Public Instruction (OPI), Healthy Mothers Healthy Babies, the Montana Highway Patrol, and the National Center for Injury Prevention and Control to explore preventive measures for reducing MVCs and resulting injuries

The 2003-2004 FICMR report was distributed to legislators of the 2007 Legislative Session and stakeholders in Montana

c. Plan for the Coming Year

CACH will coordinate with FICMR, JCHK and OPI Driver's Education Program to support legislative efforts for stronger DUI legislation, seatbelt safety, and open container laws.

Promote attendance to Child Restraint Clinics by providing schedule information to local FICMR coordinators.

Collaborate with Montana Fish Wildlife and Parks to distribute educational information on ATV Safety to Local FICMR Coordinators and Joint Committee for Healthy Kids/OPI.

Increase collaborative efforts between DPHHS DOT, OPI, Healthy Mothers Healthy Babies, Montana Highway Patrol, and the National Center for Injury Prevention and Control, to explore preventive measures for reducing motor vehicle crashes and resulting injuries in Montana.

The FICMR Coordinator will continue the collection, analysis and dissemination of FICMR data relating to motor vehicle crashes to partners and the public.

Collaborate with Healthy Mothers Healthy Babies, Safe Kids Safe Communities to distribute car safety seat educational materials to local FICMR Coordinators.

CACH staff members will continue to attend EMS Advisory Committee meetings and Injury Prevention Sub-committee meetings in order to coordinate efforts to reduce the number of child and adolescent motor vehicle deaths. They will also participate in the newly formed Injury Prevention Forum which is working toward the same goals.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | 26 |
| Annual Indicator | | | | 25.9 | 28.6 |
| Numerator | | | | 3184 | 2791 |
| Denominator | | | | 12283 | 9768 |
| Check this box if you cannot report the numerator because | | | | | |

| | | | | | |
|--|-------------|-------------|-------------|-------------|-------------|
| 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 29 | 29 | 29 | 29 | 29 |

Notes - 2006

The data source for this performance measure is WIC. Therefore, the indicator is an estimate and is not considered to represent the state population as a whole. df

Notes - 2005

These data are from the WIC program, which provides the best estimate of breastfeeding rates among mothers in Montana. The denominator includes all children under two years of age enrolled in WIC during 2005. The numerator reflects all children enrolled in WIC whose mothers reported breastfeeding them at 6 months of age.

For a historical perspective on this performance measure, see state performance measure 3.

a. Last Year's Accomplishments

The one program received a subsequent Breastfeeding Peer Counselor Grant from the State Office after completing their pilot project. The Pilot Peer Breastfeeding Counseling Grant was evaluated and expanded to other local programs. Four other programs were given the opportunity to apply for projects. Two have completed an application and will receive funds for the remainder of the year.

Breastfeeding educational materials (several items in Spanish and limited other languages, or with an emphasis on other ethnic groups) and breast pumps for participants were distributed to local programs. A new electric single-user breast pump was distributed to select local programs for review.

The Breastfeeding Coordinator joined with other interested parties in the state to form a Statewide Breastfeeding Coalition (SBC). The Nutrition and Physical Activity Program of DPHHS spearheaded the effort to establish the SBC. From the beginning, WIC and NAPA have been working together to promote and support breastfeeding in Montana.

The new chapter in the Montana WIC State Plan, Chapter 7 "Breastfeeding," was distributed to all local programs.

Breastfeeding resource materials were purchased for each local WIC program. Additional copies of the La Leche League (LLL) "The Breastfeeding Answer Book" in pocket form were purchased for peer counselors and large clinics with multiple staff.

At the Spring Public Health Conference new local staff members were offered a hands-on opportunity to examine and assemble all of the current models of breast pumps. A session on the emerging role of breastfeeding in the prevention of obesity and diabetes was presented. In August, the Missoula Nutrition Resources program sponsored "The Lactation Counselor Certificate Training Program--A comprehensive breastfeeding management course". A number of local staff members attended. There are now 36 WIC staff with CLC status and three with IBCLC status.

The Breastfeeding Coordinator attended "Using Loving Support to Build a Breastfeeding-Friendly Community" and the U.S. Breastfeeding Committee's "National Conference of State

Breastfeeding Coalitions".

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue distribution of manual and electric breast pumps to local WIC agencies. | | X | | |
| 2. Continue to provide early pre-hospital breastfeeding education to WIC parents. | | | X | |
| 3. Continue Peer Breastfeeding Counselor Projects through local WIC agencies. | | | X | |
| 4. Support local WIC staff with continuing education unit modules for certified lactation counseling and additional training. | | | | X |
| 5. Implement monitoring of local projects | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Breastfeeding Peer Counselor Projects (BPCP) are currently operating in Ravalli, Deer Lodge, Cascade, and Custer counties. Two sites, Missoula, including the Salish and Kootenai (Flathead Reservation), and the Blackfeet tribe, have accepted the program and are planning to start soon.

BPCP funds paid for a Missoula staff member to receive technical assistance in Washington on establishing a local level BPCP. Two breastfeeding peer counselors from Deer Lodge attended the "The Lactation Counselor Certificate Training Program."

A standard monitoring tool was created and reviewed with BPCPs.

Breastfeeding education materials and breast pumps continue to be distributed.

The Breastfeeding Coordinator (BC) is participating in the Statewide Breastfeeding Coalition which has now joined Eat Right Montana Coalition as a subcommittee.

In the 2007 MT Legislature passed Senate Bill 89, sponsored by the Montana Dietetic Association and supported by multiple partners. SB 89 requires policies and reasonable accommodations of space and unpaid time to support breastfeeding mothers employed by state and local governments and school and university systems. The BC provided draft supporting testimony for the Department, answered questions and provided information to local WIC programs about the bill.

The BC attended the 2007 Mother Baby Symposium in Billings. Additional staff from local BPCPs attended using WIC funds to pay some of the expenses.

c. Plan for the Coming Year

The WIC program for the State of Montana plans to continue the Peer Breastfeeding Counselor Projects at the six local programs and will request additional funds when redistribution funds are offered.

Staff will implement the BPCP monitoring tool and establish a monitoring schedule to visit each local BPCP at minimum of once every two years.

Breastfeeding educational materials that provide a standardized breastfeeding message will be purchased and distributed statewide. The materials will include those written in other languages, i.e. Spanish and will also include those targeted to other racial groups, i.e. Chinese, Vietnamese, and Native American

Staff members will participate in the Statewide Breastfeeding Coalition. They will also encourage local programs to participate in World Breastfeeding Week and to share their activities.

Available operational adjustment funds will be used to purchase additional self-study modules which can be used to earn Certified Lactation Counselor (CLC) continuing education credits. The evaluation planned for last year was not completed. Local program staff will be contacted about the utilization of these modules and use in the renewal process. If local staff did not utilize the modules or maintain CLC status, their additional modules will not be purchased with state funds.

The program plans to continue to purchase and distribute multiple types and brands of breast pumps to local WIC agencies.

The Western States Contracting Alliances sole-source bid for breast pumps will be monitored for potential participation in future years.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 98 | 98 | 98 | 98 | 92 |
| Annual Indicator | 90.1 | 90.0 | 92.8 | 87.9 | 90.0 |
| Numerator | 9810 | 10144 | 10563 | 10157 | 11107 |
| Denominator | 10886 | 11276 | 11378 | 11551 | 12339 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 92 | 92 | 92 | 92 | 92 |

Notes - 2006

The numerator data source for this is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from vital stats and includes births to Montana residents that occurred in Montana in 2006. It does not include births to Montana residents that occurred out of state. The denominator was updated with final vital statistics data for the September submission of the block grant. cz,df

Notes - 2005

Preliminary birth cohort for Montana in calendar year 2005 is 11,551.

Reset the objectives for 2006 to 2010 to address the issue of early discharge which impacts testing.

a. Last Year's Accomplishments

During calendar year 2006, Montana continued to have a voluntary newborn hearing screening program. In 2006, all hospitals in Montana, still providing obstetric services, participated in the voluntary reporting of screening results with varying degrees of completeness. (Completeness ranged from reporting of 100% screened to 2% screened.) HI*TRACK software was provided to all the birthing hospitals to ensure standardized reporting of screening information. (Prior to 2006, raw numbers of screens were compared with numbers of birth certificates issued for births. Duplicate records, screening of babies not born in the reporting hospital, and non-Montana births had not been excluded from the calculations.) Ninety-four percent (94%) of the live births in Montana were entered into the newborn hearing screening software. Eight-nine percent (89%) of the live birth babies were screened prior to hospital discharge and 91% by one month of age. Twenty-one percent (21%) of the babies born outside of hospitals were reported screened, leaving 117 such babies with no report of screening.

The Universal Newborn Hearing Screening and Intervention Task Force completed their facilitated meetings to make formal recommendations to the program on specific issues in early 2006. They recommended that newborn hearing screening become mandatory and that Administrative Rules be promulgated to specify the procedures to be carried out by all birthing facilities, midwives and audiologists in the state to ensure complete and accurate reporting. In line with that recommendation, the Department prepared legislation and secured sponsorship for the January 2007 Montana State Legislative session to accomplish that charge.

Work continued with the Montana School for the Deaf and Blind to establish what specific reporting requirements they needed when using the Children's Health Information and Referral (CHRIS) system. The CHRIS system interfaces with the HI*TRACK system for electronic referral of babies with confirmed hearing loss.

Unfortunately, the planned collaboration of the audiologists who contract with the Office of Public Instruction to perform Child Find activities under the state-supported Hearing Conservation Program with the birthing facilities was not embraced by the birthing facilities as a whole. The reasons for this lack of involvement will be explored during the process of developing the Administrative Rules for the mandatory program.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Link newborn hearing screening data with matched newborn bloodspot testing data and Birth Certificate data. | | | | X |
| 2. Continue to contract for Help Desk technical assistance for use of the tracking software by birthing facilities and audiologists | | | | X |
| 3. Track newborn hearing screening and audiological assessment results from the tracking software and communicate results to screening and assessment partners statewide. | | | X | |
| 4. Electronically refer infants diagnosed as deaf or hard of hearing to the Montana School for the Deaf and Blind within six months of each child's birth. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |

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|-----|--|--|--|--|
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In May 2007, House Bill 117 making newborn hearing screening and reporting mandatory passed the Montana Legislative Session and was signed into law. Administrative Rules will be promulgated through the formal state process and are anticipated to be completed by December 7, 2007.

c. Plan for the Coming Year

The primary focus of calendar year 2008 will be promulgation and implementation of Administrative Rules of Montana for: screening all Montana's newborns born in birthing facilities or attended by a professional; assessing the hearing status of babies who did not pass their screenings; referring babies diagnosed as deaf or hard of hearing for appropriate services and tracking by the Montana School for the Deaf and Blind; and, consistent, timely reporting of screening, assessment, and intervention services by local service partners.

Program staff will conduct ARM trainings across the state to orient local service partners to the requirements and to answer questions about implementation. The feasibility of web-enabling the tracking system is totally dependent on the amount of system development funding available.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 17 | 16 | 16 | 9 | 16 |
| Annual Indicator | 17.0 | 17.0 | 17.0 | 17.0 | 16.2 |
| Numerator | 39207 | 38755 | 38755 | 38755 | 37000 |
| Denominator | 230630 | 227972 | 227972 | 227972 | 228000 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 16 | 15 | 15 | 15 | 15 |

Notes - 2006

The numbers reflect the number of children under 18 years of age who were not covered by any public or private health insurance at some point during the reporting year. Montana Kids Count is the source of these data, which is the same source used by MT CHIP. Discussions about the most appropriate way to estimate uninsured children are underway in MT DPHHS. This data source will be reviewed and may be revised for the 2009 MCHBG application. df

Notes - 2005

The numerator for this performance measure is based on the 2003 Montana Household Survey, which asked about insurance among youth ages 18 years and younger. The survey results indicated that 17% of Montana's children were uninsured. Montana's CHIP program uses this survey as its estimate of uninsured children in the state. The denominator is the 2003 census

estimate for children 18 years of age and younger.

The Current Population Survey, conducted by the US Census Bureau, is an alternative source of information for this performance measure. In 2005, it estimated that 19.5% of children 0-17 in Montana were without health insurance coverage. However, the number of households surveyed (78,000 nationwide) is small and so this survey is used only as a comparison.

The target of 9 for 2005 was unrealistic and was reset prior to MCHBG initial submission.

Notes - 2004

The numerator for this performance measure is based on the 2003 Montana Household Survey, which asked about insurance among youth ages 18 years and younger. The survey results indicated that 17% of Montana's children were uninsured. Montana's CHIP program uses this survey as its estimate of uninsured children in the state. The denominator is the 2003 census estimate for children 18 years of age and younger.

a. Last Year's Accomplishments

At the end of FFY 2006 there were 13,112 children enrolled in CHIP and no waiting list. This represented a 14% increase in enrollment from the same time period in FFY 2005. The program continued to receive solid support from the Governor's Office, the legislature, families with CHIP coverage and the general public.

CHIP screens all applications for Medicaid eligibility and forwards all applicants who appear potentially eligible for Medicaid to local public assistance offices. We provide information about the Caring Program for those children found to be over income for CHIP. The program refers to and coordinates with Children's Special Health Services and Children's Mental Health Services.

The program sends information about the Primary Care Association members (Community Health Centers, National Health Service Corps sites, and Migrant and Indian Health clinics) to all families who apply for CHIP.

CHIP also provides information and referrals to Blue Care, Montana Youth Care and Montana Comprehensive Health Association. Callers to the Department's Family Health Line can also receive resources and referrals to private, low-cost health insurance and other resources in their communities.

CHIP continues to develop its statewide network of health care associations, individual health care providers, and related agencies to increase CHIP awareness by distributing CHIP materials in their communities. The program also conducted the train-the-trainer workshops in communities throughout the state. In addition, CHIP conducted a statewide media campaign in spring 2006.

Upon request of the Indian Health Service (HIS) and tribal health directors, CHIP conducted informational/outreach meetings with all seven reservation tribal health/IHS departments emphasizing how CHIP works in conjunction with Indian Health Services/tribal health, incorporating hands-on training to help families apply for CHIP. The program also developed and distributed a brochure insert and poster addressing advantages of Native American participation in CHIP.

In 2006 CHIP implemented the Extended Mental Health Plan for children with serious emotional disturbances (SED). This plan provides benefits in addition to the mental health benefits provided in the basic CHIP plan.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Acquire state and local funds to match federal funds and continue to insure Montana children. | | | | X |
| 2. Refer 100% of children not eligible for CHIP to other appropriate programs or plans. | | X | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

CHIP continues to provide quality, comprehensive insurance coverage for Montana children. CHIP changed from purchasing a fully insured plan to a third party administrative (TPA) contract with Blue Cross Blue Shield of Montana (BCBSMT) effective October 2006.

Effective July 1, 2007 the income guidelines were changed from 150% to 175% FPL (\$36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs. CHIP is currently developing the policies and procedures for this program.

c. Plan for the Coming Year

CHIP will continue to provide quality, comprehensive insurance coverage for Montana children. Due to legislative action taken during the 2007 legislative session to increase CHIP eligibility to 175% FPL, CHIP will broaden its community partnerships and outreach efforts. The projected enrollment for FFY 2008 is 16,000 children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | 25 |
| Annual Indicator | | | | 26.6 | 32.5 |
| Numerator | | | | 3447 | 3629 |
| Denominator | | | | 12936 | 11169 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 30 | 30 | 30 | 30 | 30 |

Notes - 2006

df

Notes - 2005

The reported denominator includes all children ages 2-5 enrolled in WIC during 2005. The numerator reflects all children with risk codes 16 and 17.

a. Last Year's Accomplishments

State WIC staff participated in the development and review of the 2006-2010 Montana Nutrition and Physical Activity (NAPA) State Plan to prevent Obesity and Other Chronic Diseases, particularly with Goal 4: Increase Breastfeeding of Montana Infants. An off-shoot of this goal was the establishment of a Statewide Breastfeeding Coalition to provide a cohesive group for breastfeeding promotion and support within Montana.

At the Spring Public Health Conference a session on the emerging role of breastfeeding in the prevention of obesity and diabetes was presented.

The Eat Right Montana Coalition Healthy Families Newsletter is provided to all local programs. This year's theme is Eat Local, Play Local, Live Healthy. Information contained in the monthly Newsletter can be used for news releases or nutrition education for participants.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Work to achieve Goal 4 of the MT Nutrition and Physical Activity State Plan to Prevent Obesity and Other Chronic Diseases. | | | | X |
| 2. Disseminate the Healthy Families Newsletter. | | | X | |
| 3. Promote and support breastfeeding. | | | X | |
| 4. Policy and Procedure Review | | | | X |
| 5. Review of nutrition education materials (overweight and obesity focused) | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The 2007 Legislature passed SB 89 requiring state and local governments and school and university systems to create employee policies supporting workplace breastfeeding and providing reasonable accommodations for breastfeeding employees to pump while at work. The Department provided supporting testimony and various partners outside of state government worked for its passage.

The Breastfeeding Coordinator (BC) participates in the Cardiovascular Disease/Obesity Prevention Task Force. One goal of the Task Force is to increase breastfeeding as a method of obesity prevention and includes establishing a Statewide Breastfeeding Coalition (SBC).

The SBC has become a subcommittee of the Eat Right Montana Coalition (ERM). ERM continues to have an agenda appropriate for WIC and targets the same population. The BC participates on conference calls and attended the June 2007 face-to-face meeting of both.

The ERM Healthy Families Newsletter is distributed to local WIC programs. The year's theme, Eat Together Play Together, focuses on family meals and activities. Information in the newsletter is used for news releases and nutrition education.

Value Enhanced Nutrition Education (VENA) training is being provided to local program staff. Role playing incorporating examples of how to approach discussions of overweight/obesity is used along with a video, "Beyond Nutrition Counseling: Reframing the Battle Against Obesity". More segments of VENA training are planned for the next two years.

c. Plan for the Coming Year

During the remaining two years of VENA implementation, current policies and procedures will be reviewed and modified when necessary to provide more participant-centered nutrition education. Overweight and obesity will be addressed when it is indicated by the participant as a focus.

Staff will review other states' materials and investigate the development of nutrition education materials addressing appropriate portion sizes for young children and infants. New materials will be distributed to the local WIC staff.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | 15 |
| Annual Indicator | | | | 15.9 | 15.9 |
| Numerator | | | | 1668 | 1668 |
| Denominator | | | | 10509 | 10509 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 15 | 14 | 14 | 13 | 13 |

Notes - 2006

The numerator and denominator are from the 2002 PRAMS data collected from mothers in a Point In Time (PIT) state sample. This is the only source of population-level data available on maternal smoking during the last three months of pregnancy. Vital statistics currently does not collect data on maternal cigarette smoking by gestational age.

A new birth certificate will be implemented in 2008 and will include a question on smoking prior to pregnancy and by trimesters of pregnancy. This is expected to provide a new source of data for this performance measure as of the 2010 MCHBG application. df

Notes - 2005

The numerator and denominator came from the 2002 PRAMS data collected from mothers in a Point In Time (PIT) state sample. This is all the data we have on mothers during the last three

months of pregnancy. Vital stats data does not contain cigarette smoking by trimester of pregnancy.

a. Last Year's Accomplishments

This performance measure was new as of this block grant application. In the past, Montana has reported on the percent of pregnant women who abstain from smoking during pregnancy, using vital statistics data (see State Performance Measure 6). The state does not have a reliable, ongoing source of information on smoking specifically in the last three months of pregnancy. A point-in-time Pregnancy Risk Assessment Monitoring Survey (PRAMS) was conducted in 2002 and the data were analyzed in 2004-2005. The survey results show that 15.9 percent of PRAMS participants smoked in the last three months of pregnancy. This is expected to be an underreporting of the actual frequency of smoking.

The CACH section has contracted with 14 counties and 2 reservations to provide Public Health Home Visiting (PHHV) to at risk pregnant and/or women parenting an infant less than one year of age. An additional 6 Fetal Alcohol Spectrum Disorder (FASD) sites were contracted with to provide intensive case management services to pregnant women at very high risk for abusing alcohol, tobacco and other drugs (ATOD). FASD services include assisting with accessing quality health care early in pregnancy; family centered coordinated care, community resource referral, advocacy, health education, and risk reduction for risk factors associated substance use.

Montana's tobacco quit line information has been distributed at PPHV and FASD staff trainings and through emails to the 16 PPHV contractors and 6 FASD contractors.

In June 2006 the FASD Support Specialists received training on addiction and heard testimonials from women in substance abuse treatment. This information was shared at the October 2006 annual FASD Advisory Council Meeting.

The CACH PPHV/Perinatal Substance Abuse nurse consultant participated in the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA), a statewide steering committee, to develop a needs and resource document for women involved in intimate partner violence.

CACH manager attended the quarterly Family and Community Health Bureau (FCHB) advisory council meetings and provided up-to-date information on the FASD and PPHV programs.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Public Health Home Visiting (PHHV)/Perinatal Nurse consultant will serve as a consultant to statewide advisory councils. | | | X | |
| 2. PPHV/Perinatal Nurse consultant will act as a consultant for the PPHV and FASD prevention home visiting projects which promote smoking cessation during and after pregnancy. | | | | X |
| 3. Continue to fund 15 PPHV sites and 6 FASD sites to promote smoking cessation during pregnancy | | | | X |
| 4. Collaborate with Montana Tobacco Use Prevention Project (MTUPP) to plan training for the PPHV and FASD staff on smoking cessation. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

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|-----|--|--|--|--|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Current funding levels for the PHHV and FASD programs is being maintained.

Use of standardized screening tools (American College of Obstetricians and Gynecologists (ACOG) domestic violence against women, T-ACE alcohol screen, and Edinburgh Postnatal Depression Scale (EPDS) and the life skill progression (LSP) tool) help the PHHV/FASD team members identify risks and coordinate care for their clients

CACH section staff is collaborating a with the Indian Health Service (IHS) and reservation public health nurses to promote participation in the PHHV programs

A training for the FASD Support Specialist (SS) focusing on motivational interviewing (MI) which is a method that teaches the SS how to collaborate with their client and promote behavioral changes

The CACH section is collaborating with Montana's Tobacco Use Prevention Program (MTUPP) to provide a training on tobacco cessation for clients served by the PHHV and FASD programs

CACH Section and PHHV contractors are working on development of a business plan which to collaboratively think through program activities, evaluate these activities to increase effectiveness and efficiency, and describe what information system is needed for program support

PHHV/Perinatal Substance Use Prevention nurse consultant provides technical assistance and support to the FASD Support Specialists through bi-monthly conference calls

c. Plan for the Coming Year

CACH plans to facilitate and organize the yearly FASD Advisory Council meetings.

The CACH PHHV/Perinatal Substance Use Prevention nurse consultant will continue to offer technical support to the FASD Support Specialist's (SS) through coordinating and facilitating bi-monthly conference calls with the local SS

CACH will continue to contract with the current PHHV and FASD Programs, as well as recruit additional counties and tribes to provide PHHV and FASD Prevention activities and to promote smoking cessation throughout pregnancy.

The Fetal Infant Child Mortality Review (FICMR) Coordinators and State Team will be trained on smoking cessation activities and the importance of quitting during pregnancy at their annual meeting.

The MTUP collaboration and planning for the Spring 2008 Training on tobacco cessation, NRT, community resources, medications, and Medicaid coverage for tobacco cessation for PHHV and FASD program will continue.

CACH will continue to work with the statewide PHHV Program and MCH block grant stakeholders to develop business plan. The business plan requires CACH section and its contractors to collaboratively think through its program activities, evaluate these activities to increase effectiveness and efficiency, and describe what information system is needed for program support.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 11 | 10.2 | 9.5 | 10 | 10 |
| Annual Indicator | 14.0 | 16.9 | 17.7 | 26.6 | 13.4 |
| Numerator | 10 | 12 | 12 | 18 | 9 |
| Denominator | 71310 | 71149 | 67913 | 67608 | 67029 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 10 | 9 | 9 | 9 | 9 |

Notes - 2006

The Montana Office of Vital Statistics is the source of the numerator data. 2006 vital statistics data were finalized for the September submission. Denominator data are from the 2006 census estimates for the population of 15-19 year olds in the state (released in 2007). df

Notes - 2005

Denominator data was derived from 2004 Census estimates for Montana children ages 15 to 19 years of age. Numerator data was derived from Vital stats in 2006. PLEASE NOTE: DENOMINATOR DATA WERE UPDATED IN 2007 TO REFLECT THE MOST RECENT CENSUS ESTIMATES FOR 2004.

Despite the disparity between objective and indicator, Montana is retaining this objective. Two youth suicide projects, funded in part by federal grants, began in late 2005/2006.

Notes - 2004

Denominator data was derived from 2004 Census estimates for Montana children ages 15 to 19 years of age. PLEASE NOTE: DENOMINATOR DATA WERE UPDATED IN 2007 TO REFLECT THE MOST RECENT CENSUS ESTIMATES FOR 2004. Numerator data was updated from Vital stats in 2006.

a. Last Year's Accomplishments

The Child, Adolescent & Community Health Section (CACH) was awarded the Garrett Lee Smith Memorial Act federal grant for suicide prevention activities in September 2005. The Montana Youth Suicide Prevention (YSP) Project provided funding to communities to address risk and incidences of suicide attempts and completions, and implement evidence-based programs to reduce youth suicide

In October 2006, DPHHS, CACH Section through a Request for Proposal process, funded 12 sites in Montana to address youth suicide. The 12 funded communities designed intervention activities based on activities specific to each community. The site specific activities include:
Media and Promotional Activities: Newsletters, Informational workshops, Posters, Wallet cards, Web sites, Brochures, Books, Videos/DVD, Public service announcements through newspapers, radio and television, and Prevention resource guides

Coordination, Networking and Collaborative Activities:

Efforts are directed through a variety of organizations and entities such as Montana Hospitals/Hospital Association, MT Department of Public Health and Human Services, mental health services/associations, universities, child welfare, etc. The programming includes: Develop local suicide prevention plans, Improve mental health services, Conduct policy reviews in settings such as schools as it relates to suicide prevention, Identification of mental health service gaps, Provide free suicide attempt debriefing services with licensed mental health providers, Train area school counselors as American Foundation for Suicide Prevention suicide survivor facilitators, implement an ER hospital referral process, Develop community crisis response plans, Develop community based task forces on youth suicides, and Conduct community assets mapping Screening and Gatekeeper Activities: Question, Persuade & Refer (QPR), the Columbia TeenScreen Program, Yellow Ribbon Day, Depression Screenings

Statewide YSP Task Force meetings were held during March, May, and November 2006 and March 2007

The YSP Project Director in the CACH Section collaborated with the MT/WY TLC's Planting Seeds of Hope (PSOH) Suicide Prevention Project by attending technical advisory board meetings held in August and October, 2006 and January 2007.

DPHHS YSP staff in the CACH Section partnered with the MT/WY TLC to provide a two day Applied Suicide Interventions Skills Training (ASIST) to DPHHS and MT/WY TLC suicide prevention contractors

Information about the YSP Project was presented to the Systems of Care committee to assist in coordination efforts

Following a suicide at a local high school, the YSP Project Director was interviewed by a local TV station. Information for parents on warning signs and helping their children cope after this suicide was included in the interview which aired during the local news. The Suicide Prevention Resource Center handout on the role of the media in preventing suicide was given to the local newspaper and TV station

The Montana Strategic Suicide Prevention Plan was finalized in December 2006 and given to Legislators in January 2007

The YSP project director and project coordinator in CACH prepared testimony for the Bureau Chief, who worked with Legislators and Montana Mental Health Association on a suicide prevention bill. The Bureau Chief presented the testimony in support of a bill. The bill was passed into law and will help sustain suicide prevention activities and expand activities and fund a statewide coordinator to coordinate suicide prevention efforts across the lifespan

The YSP Project Coordinator participated in the Joint Committee for Healthy Kids (JKHK) to help coordinate prevention efforts between DPHHS and the Office of Public Instruction.

The YSP Project Director and Project Coordinator served as consultants to the State Fetal, Infant, Child Mortality Review (FICMR) Team

A November 2006 a statewide press release from the CACH Section provided information on YSP and identified the 12 communities funded to provide YSP activities

The Spring 2007 Prevention Connection published by the Montana DPHHS Prevention Resource Center printed an article about Montana's Youth and Young Adult Suicide Prevention Project

YSP Project Coordinator facilitated a panel of local YSP project participants to present information on Montana's Youth and Young Adult Suicide Prevention Project at the May 2007

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Youth Suicide Prevention Coordinator will serve as consultant to the State Fetal, Infant, and Child Mortality Review (FICMR) team on topics related to youth suicide prevention. | | | | X |
| 2. Twelve communities funded for evidence-based youth suicide prevention projects. | | | | X |
| 3. Present a media awareness workshop to inform media on best practices for suicide reporting. | | X | | |
| 4. Advocate with CHIP and Medicaid programs to serve youth with acute care suicidal needs | | X | | |
| 5. Work with the state Prevention Resource Center (PRC) and media to promote the idea that suicide is a preventable public health problem. | | X | | |
| 6. Coordinate tribal and state efforts to reduce youth suicide across the state. | | | | X |
| 7. Collaborate with and support Office of Public Instruction (OPI) efforts to pass a statewide policy on bullying in schools. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FICMR teams review all youth suicides to identify prevention strategies. The CACH YSP consultant and the YSP Project Director attend the State FICMR team and local FICMR coordinator meetings. Information and consultation is provided regarding YSP prevention efforts

12 communities continue to receive funds and technical assistance for their youth and young adult suicide prevention projects

Montana's YSP Task Force meets twice a year to share information, and reviews best practices for suicide prevention, disseminates the recommendations, and oversees the activities implemented through the federal funding

The YSP Project Director is a member of the MT/WY TLC PSOH Suicide Prevention Project Technical Advisory board and the PSOH project Director is a member of the DPHHS statewide YSP Task Force.

CACH supports QPR and ASIST trainings and the YSP Consultant helps assure training is available throughout Montana and identifies and encourages other best practice methods to prevent suicidal behaviors among youth.

CACH staff promotes a coordinated effort in youth suicide prevention by partnering with the Joint Committee for Healthy Kids, Juvenile Justice, Children's Mental Health, Private Healthcare Providers, Emergency Medical Services for Children (EMSC), The Faith-Based Community, Children's Special Health Services, and Connecting for Kids, Mt/WY TLC, and Billings Area Indian Health Service (BAO IHS)

c. Plan for the Coming Year

CACH plans the following suicide prevention activities for 2008:

Continue attending Connecting for Kids committees to promote and increase access to and linkages with Mental Health and Substance Abuse Services.

Work with schools and multiple systems through the Joint Committee for Healthy Kids (JCHK), Juvenile Justice, and Children with Special Health Care Needs (CSHCN), and Connecting for Kids to promote youth suicide prevention across the systems.

Provide technical assistance to the twelve community projects for the implementation of evidence-based practices for the prevention of suicide among Montana's youth and young adults (ages 10-24).

Conduct bi-yearly meetings of the Suicide Prevention Task Force.

Collaborate with the MT/WY TLC PSOH Project by attending technical advisor board meetings and inviting the PSOH Project Director to provide an update at each of our YSP Task Force Meetings.

Contract with the Montana Mental Health Association to create and disseminate a youth driven public service announcement around mental illness, suicide and stigma.

Coordinate the delivery of Applied Suicide Intervention Skills Training (ASIST) throughout the state.

Present the Youth and Young Adult Suicide Prevention Project at the MT Public Health Association Conference.

Increase public awareness that youth suicide is a preventable public health problem by writing two articles for newsletters, magazines or newspapers and one press release.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 86 | 86.5 | 90 | 90 | 91 |
| Annual Indicator | 75.8 | 88.7 | 78.7 | 77.2 | 80.3 |
| Numerator | 91 | 102 | 100 | 88 | 114 |
| Denominator | 120 | 115 | 127 | 114 | 142 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 91 | 91 | 91 | 91 | 91 |

Notes - 2006

The data source for this performance measure is the MT Office of Vital Statistics. 2006 data were finalized for the September submission of the Block Grant. In 2006, Montana had three level 3

facilities (facilities for high-risk deliveries and neonates). The numerator and denominator include only infants born to Montana residents that occurred in Montana. df

Notes - 2004

Trend analysis from 2000 to 2004 indicated an actual decrease in the percent of very low birth weight deliveries, with a 2010 projection of 75.12%. Projections were reset to accommodate for that downward trend in deliveries.

a. Last Year's Accomplishments

Child Adolescent and Community Health section (CACH) provided training opportunities on assessment tools and interventions to the Public Health Home Visiting Programs. (PHHV)

CACH continued to revise and implement changes to data reporting tools to further enhance data collection and retrieval.

CACH contracted with 14 counties and 2 reservations to provide Public Health Home Visiting (PHHV) to at risk pregnant and/or women parenting less than one year old infants. In addition 6 Fetal Alcohol Spectrum Disorder (FASD) sites were contracted with to provide intensive case management services to pregnant women at very high risk for abusing alcohol, tobacco and other drugs (ATOD). Services include assisting with accessing quality health care early in pregnancy; family centered coordinated care, community resource referrals; advocacy; health education; and risk reduction.

Ongoing support to the 51 Fetal Infant Child Mortality Review (FICMR) community coordinators continued through informational Electronic mailings and coordination of two (2) local FICMR coordinator meetings.

2003 and 2004 FICMR data was collected and analyzed by a contracted Maternal Child Health (MCH) epidemiologist.

The 2003-04 FICMR report was completed and shared with legislators and state and local stakeholders and is intended to help identify prevention or intervention activities in order to decrease the number of fetal, infant, and child deaths.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Serve as statewide consultant to the PHHV and FASD Prevention projects related to prematurity prevention. | | | | X |
| 2. PHHV Nurse Consultant will act as coordinator for the FASD and PHHV Projects, arranging site visits and training as needed. | | | X | |
| 3. Fund 15 PHHV Projects and 6 FASD Prevention Projects. | | X | | |
| 4. Make most current FICMR data report available to stakeholders and Legislators. | | | X | |
| 5. Advocate with Medicaid program to continue the provision of Targeted Case Management (TCM) services to at risk pregnant women. | | | | X |
| 6. Coordinate State and Tribal efforts to prevent prematurity. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The FASD program year end evaluation report submitted to the SAMSHA subcontractor (Northrop Grumman) and the FASD program contractors January 2007

FASD Support Specialists attended Motivational Interviewing (MI) training coordinated by CACH staff. The MI training addressed how to collaborate with your client and promote behavioral changes.

Use of standardized screening tools (American College of Obstetricians and Gynecologists (ACOG) domestic violence against women, T-ACE alcohol screen, and Edinburgh Postnatal Depression Scale (EPDS) and the life skill progression (LSP) tool) help the PHHV/FASD team members identify risks and coordinate care for their clients

The CACH section is collaborating with Montana's Tobacco Use Prevention Program (MTUPP) to provide a training on tobacco cessation for clients served by the PHHV and FASD programs

CACH Section and PHHV contractors are working on development of a business plan which to collaboratively think through program activities, evaluate these activities to increase effectiveness and efficiency, and describe what information system is needed for program support

CACH PHHV/Perinatal Substance Abuse Prevention Nurse Consultant provides on site follow up trainings for the PHHV programs on the Life Skill Progression (LSP) tool.

c. Plan for the Coming Year

CACH will continue with yearly FASD Advisory council meetings and bi-monthly FASD Support Specialist conference calls.

Funding will continue for the 15 PHHV Projects and 6 FASD Prevention sites and there will be community outreach activities directed to recruiting additional PHHV and FASD sites.

A business plan for the PHHV program and MCH block grant will be developed. The business plan requires DPHHS and its contractors to collaboratively think through the activities performed to meet the program goals, rethink the activities to increase effectiveness and efficiency, and describe what the information systems must do to support program.

March of Dimes' prematurity prevention educational materials will be distributed to local FICMR Coordinators and Early Child Comprehensive Services (ECCS) school readiness team, and Healthy Mothers and Healthy Babies.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 84.5 | 85 | 85.5 | 86 | 85.4 |
| Annual Indicator | 83.3 | 84.1 | 82.6 | 83.5 | 83.2 |
| Numerator | 9067 | 9571 | 9513 | 9528 | 10268 |
| Denominator | 10886 | 11384 | 11514 | 11414 | 12339 |
| Check this box if you cannot report the numerator because | | | | | |
| 1. There are fewer than 5 events over the last year, | | | | | |

| | | | | | |
|--|-------------|-------------|-------------|-------------|-------------|
| and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 85.9 | 86.4 | 86.9 | 87.4 | 87.4 |

Notes - 2006

The data source for this performance measure is the Office of Vital Statistics, Montana DPHHS. 2006 data were finalized for the September submission of the Block Grant. Data reflect births to Montana residents that occurred in Montana in 2006. df

Notes - 2004

Trend analysis was completed for this measurement.

a. Last Year's Accomplishments

Montana contracted with 14 counties and 2 reservations to provide Public Health Home Visiting (PHHV) services to at risk pregnant women and/or women parenting a less than one year old infant. An additional 6 Fetal Alcohol Spectrum Disorder (FASD) sites were contracted with to provide home visitation services to pregnant women at very high risk for abusing alcohol, tobacco and other drugs (ATOD). Technical assistance trainings were provided on the Life Skills Progression (LSP) tool and maternal depression for the PHHV staff.

On June 27, 2006, the FASD Support Specialist attended a training on addiction and heard testimonials from women in treatment for substance use on what interventions worked for them. The evaluations and testimonials for this training were very positive.

CACH Manager and the Child Health Nurse Consultant continued participation in the Early Childhood Comprehensive Services (ECCS) core group meetings and implementation of the ECCS strategic plan which includes development of partnerships and collaborative administration focusing on early childhood and family support.

Public Health Home Visiting professionals were required to establish and maintain a mechanism for identifying high-risk pregnant women.

PHHV staff received training on the Ages and Stages and the Ages and Stages Social Emotional (ASQ and the ASQ/SE) developmental screening questionnaires which are used to identify infants and children at risk for delays.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue to support legislative efforts to improve Medicaid reimbursement rates for Medicaid providers. | | | | X |
| 2. Pursue grant funding for the FASD program. | | | | X |
| 3. Collaborate with statewide stakeholders to develop a business plan for the maternal child health (MCH) block grant and PHHV program. | | | | X |
| 4. Provide continuing education for PHHV and FASD staff at a minimum of two times per contractual year. | | | X | |
| 5. PHHV nurse consultant to participate in advisory council and steering committee to represent the needs of the prenatal population. | | | | X |
| 6. | | | | |
| 7. | | | | |

| | | | | |
|-----|--|--|--|--|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The FASD Program year end evaluation report was submitted to the grantee SAMSHA and the program contractors.

Annual training on motivational interviewing (MI) was provided for FASD Support Specialists. The MI training addressed how to collaborate with your client and promote behavioral changes.

The State will continue to fund and contract with at least 15 PHHV sites and 6 FASD sites. CACH section will visit with the MCH Consultant from the Billings Area Office Indian Health Services, to explore means to recruit new PHHV reservation sites.

Collaborate with statewide stakeholders for the PHHV program and MCH block grant to develop a business plan. The business plan requires CACH section and its contractors to collaboratively think through the activities performed to meet the program goals, rethink the activities to increase effectiveness and efficiency, and describe what the information systems must do to support program.

On-site follow up trainings on the Life Skill Progression Tool (LSP) will be provided to PHHV contractors.

DPHHS contracts with local providers of PHHV and FASD require that they continue to have an interagency and community referral mechanism to identify high risk pregnant women and link them with appropriate community services early in their pregnancy

CACH PHHV/Perinatal Substance Use Prevention nurse consultant participates in a statewide steering committee to develop a needs and resource document for women involved in intimate partner violence.

c. Plan for the Coming Year

FASD Advisory council meetings will continue.

Staff will facilitate bi-monthly conference calls with FASD Support Specialist.

The Child and Adolescent Community Health section (CACH) will collaborate with Montana Tobacco Use Prevention Program (MTUPP) to provide PHHV and FASD home visiting staff training on tobacco cessation. The training will include information on nicotine replacement, medication, and community resources for tobacco cessation.

The State of Montana will continue to provide funding for the PHHV and FASD sites through contractual agreements and conduct community outreach to recruit more PHHV and/or FASD sites.

CACH section will continue to collaborate with PHHV contractors to develop a business plan for the MCH block grant and the PHHV program. The business plan requires CACH section and its contractors to collaboratively think through the activities performed to meet the program goals, rethink the activities to increase effectiveness and efficiency, and describe what the information systems must do to support program.

D. State Performance Measures

State Performance Measure 1: *Percent of unintended pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|---------------------------------------|------|------|------|-------|-------------|
| Annual Performance Objective | 52 | 54 | 52 | 63 | 62 |
| Annual Indicator | 64.8 | 66.1 | 64.6 | 64.0 | 64.0 |
| Numerator | 1261 | 1189 | 1200 | 1251 | 1281 |
| Denominator | 1946 | 1799 | 1858 | 1955 | 2002 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 62 | 61 | 61 | 60 | 60 |

Notes - 2006

The denominator is total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies. Due to data collection changes this is an estimate.

Notes - 2005

The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies.

Notes - 2004

The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies. 2009 Revised trend would be 60.6. We recognize challenges with decreasing this unintended rate, which is impacted by factors other than health care access.

a. Last Year's Accomplishments

Unintended pregnancy prevention remains one of sixteen priorities in the Montana Health Agenda, a road map for health service and program action, particularly for the Montana Department of Public Health and Human Service's (DPHHS) Public Health and Safety Division. This priority section outlines the Department's goal to decrease unintended pregnancy and lists specific objectives relating to unintended pregnancy.

The Women's and Men's Health Section (WMHS) maintains contracts with 15 local family planning clinics to assure access to comprehensive reproductive health care for men and women of reproductive age. Additional special initiative funds provided local clinics with funding for male clinic services, satellite clinics, services for teens attending alternative schools and for Contraceptives and Technology to provide efficacious contraceptives to low-income clients.

In SFY 2006, local family planning clinics service 28,272 men and women throughout Montana. It is estimated that Title X family planning services prevented approximately 18,718 unintended pregnancies, including 2,647 abortions, during SFY 2006

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. In State Fiscal Year (SFY) 2008, provide FP services to at least 29,500 clients at risk of unintended pregnancy. | X | | | |
| 2. In SFY 2008, ensure that 97% of female FP clients using | X | | | |

| | | | | |
|--|---|--|--|---|
| contraception do not experience an unintended pregnancy. | | | | |
| 3. In SFY 2008, at least 69% of family planning clinic clients will be at or below 150% of federal poverty level. | X | | | |
| 4. In SFY 2008 provide funding to 15 agencies with services in 29 clinics for efficacious contraceptives for low-income clients (below 250% of poverty). | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

WMHS contracts with agencies to provide reproductive health care to women at risk of unintended pregnancy. Data on contraceptive use and effectiveness is monitored and evaluated. Outreach and education are provided to low-income clients (defined as 150% or less of FPL).

WMHS provides outreach materials, including fact sheets, to county Offices of Public Assistance; community action programs; Healthy Mothers, Healthy Babies; Public Health Home Visiting Programs; WIC offices; local Breast and Cervical Health Program sites; and Indian Health Services. Family planning programs also receive outreach materials and distribute them to clients and community partners. Outreach materials include the 24-hour toll-free hotline number to assist clients in finding the nearest Family Planning Clinic.

Legislation passed allows the Department to pursue a 1115 Medicaid Waiver to expand family planning services to low income women in Montana. It is anticipated that this will be submitted in SFY2008.

A referral system has been developed to allow rural agencies without the capacity to provide IUD insertions to refer these clients to larger agencies. This system increases the availability of IUDs for low-income women.

Through special funds, WMHS can support highly effective contraceptives, including emergency contraceptives, thereby reducing teen pregnancy rates as well as the teen birth rate and unintended pregnancy.

c. Plan for the Coming Year

During the coming year, the WMHS plans to address unintended pregnancy through continued contracts with its local family planning clinics providing comprehensive reproductive health care in 29 locations to residents of all 56 Montana counties. Because low-income clients are at increased risk of unintended pregnancy, the WMHS will continue to offer comprehensive family planning services targeting low-income men and women.

Through training and educational activities, the WMHS plans to assist local family planning programs in providing quality medical, clinical counseling and education services for all clients. A training needs assessment is distributed annually to local family planning clinics to develop educational goals and training programs. Such training improves the service and quality of care in reducing unintended pregnancies among clients of local family planning programs.

The WMHS will provide health education materials on unintended pregnancy to local programs and other public health partners. These materials will be updated to reflect the increased availability of information in an electronic format. The health educator will continue to investigate

on-line resources and other sources of current information that includes unintended pregnancy prevention.

The WMHS will apply for strategic initiative funding in SFY 2008 that supports targeted projects to expand clinical services to males. Strategic initiative proposals address the HP 2010 goal to reduce the rate of unintended pregnancy and two of the proposals directly target reducing pregnancies among adolescent females.

The WMHS will continue to provide special funding for efficacious contraceptives to local family planning clinics. These high-cost and highly effective contraceptives will be provided to low-income clients who fall at least below 250% of the federal poverty level.

State Performance Measure 2: *Percent of women who abstain from alcohol use in pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 98 | 98 | 98 | 98 | 98.3 |
| Annual Indicator | 96.9 | 97.2 | 97.0 | 97.0 | 96.8 |
| Numerator | 10552 | 10959 | 11203 | 11122 | 11988 |
| Denominator | 10886 | 11276 | 11554 | 11468 | 12388 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 98.5 | 98.6 | 98.7 | 98.9 | 98 |

Notes - 2006

Numerator and denominator data are from The Montana Office of Vital Statistics. The numerator includes the number of women who experienced a live birth in 2006 and reported not drinking alcohol during pregnancy, plus the number of women who experienced a fetal death in 2006 and reported not drinking alcohol during pregnancy. Denominator data includes all women who experienced a live birth or a fetal death in 2006. Vital records data on alcohol use in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence. This indicator was updated with final 2006 vital statistics data for the September submission. df

Notes - 2005

The numerator for 2004 and 2005 was generated from vital records by including the number of women delivering live births and not drinking alcohol plus the number of women experiencing fetal deaths and not drinking alcohol. Denominator data was all women either experiencing a live birth or a fetal death for the years in question. Vital records data on alcohol use in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence.

a. Last Year's Accomplishments

Montana State contracted with 14 counties and 2 reservations to provide Public Health Home Visiting (PHHV) services to at risk pregnant and/or women parenting an infant less than one year of age. In addition 6 Fetal Alcohol Spectrum Disorder (FASD) sites provided intensive case management services to pregnant women at very high risk for alcohol, tobacco and other drugs (ATOD) abuse. PHHV and FASD services include accessing quality health care early in pregnancy, family centered coordinated care, community resource referrals, advocacy, health education, and risk reduction.

On June 27, 2006 the FASD Support Specialist attended training on addiction and heard testimonials from women in treatment for substance use.

The Child Adolescent, and Community Health (CACH) section was represented at each Family and Community Health Bureau (FCHB) Quarterly Advisory Council meeting.

State wide training was provided on the following screening tools: the American College of Obstetric and Gynecologist (ACOG) Domestic Violence, Tolerance-Annoyance Cut Down Eye Opener (T-ACE), the Edinburgh Postnatal Depression Scale (EPDS), and Life Skills Progression (LSP). Contracted sites are required to report demographic data, outcomes of the screening tools, and make the appropriate referrals for the population they serve.

CACH facilitated monthly conference calls with FASD Support Specialists to provide support and technical assistance.

First year FASD program evaluation report was completed July, 2006

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue to support legislative efforts to prevent FASD through funding to support the FASD prevention projects. | | | | X |
| 2. The PHHV/FASD Nurse Consultant will work with PHHV sites, FASD sites and the FASD Advisory Council, and Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) steering committee to continue statewide efforts to reduce FASD | | | X | |
| 3. Continued collection of PHHV and FASD site data relating to FASD prevention | | | | X |
| 4. Continue to fund FASD prevention sites through funding from SAMHSA. | | X | | |
| 5. Plan yearly training(s) for the PHHV and FASD sites. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

A FASD Advisory council meeting was conducted in October 2006. Risk factors for substance use, such as family violence, and testimonials from young mothers active in the FASD program were included

Contracts with PHHV and FASD programs continue to provide services to high risk pregnant women and their infants up to one year of age. Contracted sites are using standardized screening tools for intimate partner violence (IPV), "alcohol, tobacco, and other drugs" (ATOD), depression, and life skills. Contracted sites are required to have an established referral system for high risk pregnant women within their community. CACH staff provides technical assistance and training to all PHHV and FASD sites

The PHHV/FASD nurse consultant is participating in a statewide steering committee, Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA), to develop a needs and resource document for women involved in intimate partner violence.

In January 2007 the FASD year end evaluation report was completed and submitted to the grantee.

CACH section staff is collaborating with the Indian Health Service (IHS) and reservation public health nurses to promote participation in the PHHV programs

CACH Section and PHHV contractors are working on development of a business plan which to collaboratively think through program activities, evaluate these activities to increase effectiveness and efficiency, and describe what information system is needed for program support

c. Plan for the Coming Year

Staff members will provide technical assistance and support to the FASD Support Specialists through bi-monthly conference calls.

Funding will continue for PHHV and FASD projects. CACH will respond to Substance Abuse and Mental Health Service Administration (SAMSHA) request for proposal (RFP) for continued FASD funding.

FASD Advisory Council meetings will continue on a bi-yearly or yearly basis.

CACH will collaborate with Montana Tobacco Use Prevention Program (MTUP) and plan a PHHV and FASD Spring 2008 training on tobacco cessation, nicotine replacement therapy (NRT), community resources, medications, and Medicaid coverage for tobacco cessation.

Staff members will continue to promote the PHHV program and attempt to recruit new sites.

State wide assessment and business plan development for the PHHV program will continue.

State Performance Measure 4: *Percent of state fetal/infant/child deaths reviewed for preventability by local review teams.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 95 | 95 | 95 | 95 | 95 |
| Annual Indicator | 91.1 | 88.0 | 92.8 | 94.2 | 59.5 |
| Numerator | 184 | 183 | 155 | 178 | 103 |
| Denominator | 202 | 208 | 167 | 189 | 173 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 96 | 96 | 96 | 96 | 96 |

Notes - 2006

The numerator does not represent the final number of reviews for 2006. Fetal, Infant and Child Mortality Review (FICMR) teams may review deaths and submit reviews to the state FICMR program as long as 6-12 months after the event. The denominator reflects the final number of fetal, infant and child deaths for 2006, from the Montana Office of Vital Statistics. df

Notes - 2005

Final 2005 data were entered 6/19/07. Fetal, Infant and Child Mortality Review teams may review deaths as long as 6-12 months after the event.

Notes - 2004

Data were updated in 2006.

a. Last Year's Accomplishments

The Fetal, Infant and Child Mortality Review (FICMR) program was sustained using Maternal and Child Health Block Grant (MCHBG) funding.

2003-2004 FICMR data was analyzed by a Maternal Child Health (MCH) epidemiologist, and the report was written by the State MCH Epidemiologist. It was published and distributed statewide to legislators, state, and local stakeholders to assist in identifying prevention or intervention activities in order to decrease the number of fetal, infant and child deaths.

The Child Health Nurse Consultant (CHNC) FICMR Coordinator held two Local FICMR Coordinator meetings during the past year. (The next meeting is scheduled for September 10, 2007.)

Local communities continue to conduct FICMR reviews and send data on FICMR to the Child Health Nurse Consultant (CHNC) FICMR Coordinator) on a quarterly basis.

The Child, Adolescent and Community Health (CACH) Section has regularly scheduled meetings with the WIC staff to promote educational materials on Safe Sleep for breastfeeding moms. An informational brochure has been developed and will be made available at the WIC clinics.

Staff members provided education at a local FICMR coordinators meeting in Sept. 06 about "Period of Purple Crying" for prevention of child abuse and neglect.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue to support legislation to prevent fetal, infant and child deaths in communities in Montana. | | | | X |
| 2. Distribute FICMR report on 2003-2004 data to stakeholders and legislators. | | | X | |
| 3. Promote current SUID reporting on form and scene investigation through coordination with the training staff for law enforcement officers and coroners. | | | X | |
| 4. Promote social marketing techniques to educate policy makers and the public about preventable deaths of children and infants in Montana. | | | X | |
| 5. Continued support of local FICMR teams on collection of FICMR data related to preventable deaths. | | | | X |
| 6. Inform Local FICMR coordinators of the Safe Sleep Project sponsored by Healthy Mothers Healthy Babies. | | | X | |
| 7. Provide bereavement information and resources for local FICMR coordinators use when a family is grieving over the loss of a child. | | | X | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Collaborate with Healthy Mothers Healthy Babies (HMHB) on the Safe Sleep Project by providing technical assistance (TA) and guidance.

Provide information to local FICMR coordinators on bereavement resources for families of

deceased children.

The FICMR data collection tool has been revised and support staff at DPHHS is entering information into a revised ACCESS data base.

FICMR data for 2003 and 2004 will be analyzed and the third statewide report published. The report will be available to stakeholders and legislators. The FICMR reports are released every two years to coincide with Montana's legislative sessions. Aggregating two years of data also provides a better overview of the major causes of fetal, infant and child deaths and possible prevention strategies.

CACH is collaborating with the state medical examiner and state FICMR team members to gather information on the Sudden, Unexplained Infant Death (SUID) reporting form and scene investigations. CACH hopes to be included on the training agenda for law enforcement officers and coroners this upcoming fall.

c. Plan for the Coming Year

Work with the Daycare Licensing Section to develop Administrative Rule mandating "Back to Sleep" for babies in daycare will continue through regularly scheduled meetings

CACH staff will participate on the Drug Endangered Child Task Force

Collaborate efforts with the Injury Prevention Specialist to provide educational materials highlighting injury and death prevention to local FICMR coordinators

Staff will continue collaborative effort with WIC section on Safe Sleep for breastfeeding mothers through bimonthly meetings of WIC staff and Child Health Nurse Consultant

Information on the "Safe Haven" law will continue to be provided to health departments, advisory councils, day cares, and other public-private providers in the state by the Child Health Nurse Consultant

Work will continue with the state medical examiner to educate coroners and law enforcement officers about the Center for Disease Control, (CDC) Sudden Unexpected Infant Death Investigation (SUIDI) Reporting Form by continued information sharing with the coroner and law enforcement training centers.

CACH will continue to explore the reporting of SIDS deaths as preventable by discussing with national FICMR, DPHHS epidemiologists and state and local FICMR team members regarding the reporting SIDS as preventable vs. reduction of risks associated with SIDS.

Information, including culturally sensitive informational materials on Safe Sleep for Babies, from the Healthy Native Babies Workshop on SIDS will be distributed to local FICMR coordinators.

Collaborative efforts will be continued with Healthy Mothers Healthy Babies (HMHB) on the Safe Sleep Project by providing technical assistance (TA) and guidance.

The FICMR program will be sustained at the current level through MCHBG funding and education and support from the child health nurse consultant.

CACH will also provide education at the FICMR coordinators meeting in Sept. 07 about gun safety and the proper use of gun locks.

A subcommittee of the state FICMR team will be formed to evaluate membership and governance

of State FICMR team, and make changes as needed.

State Performance Measure 5: *Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 31 | 32 | 33 | 23 | 20.4 |
| Annual Indicator | 23.7 | 23.4 | 22.6 | 23.3 | 24.5 |
| Numerator | 14123 | 14649 | 14707 | 15374 | 15066 |
| Denominator | 59578 | 62629 | 65079 | 66078 | 61369 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 19.5 | 18.6 | 17.8 | 17 | 17 |

Notes - 2006

The source for this data is EPSDT. It is run on the FFY 2006. CZ

Notes - 2005

This data came from the Early Periodic Screening Diagnostic Treatment (EPSDT) report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004

This data came from the Early Periodic Screening Diagnostic Treatment (EPSDT) report from the Montana Medicaid Program. It is an annual report for FY 2004 and was updated in 2006 with final data.

a. Last Year's Accomplishments

The Covered Services Section of the Medicaid Dental Provider Manual was updated.

Dental fee schedule code reimbursement, all Medicaid covered Current Dental Terminology (CDT) codes, CDT code allowed minimum and maximum age, and all service limitations per Code were incorporated in one convenient location.

<http://medicaidprovider.hhs.mt.gov/providerpages/providertype/18.shtml>

Dental provider informational bulletins were included in the Medicaid Provider Claim Jumper monthly newsletter. This project is completed by staff of Affiliated Computer Services, Inc. (ACS).

The 2005 Legislative session provided DPHHS with tobacco funds for the Medicaid Dental Program. These funds were used for increasing dental fees as of July 1, 2005 and for exploring projects, such as "Rent A Practice For A Day" aimed at increasing dental care in low access areas. In addition to their regular fee-for-service reimbursement, providers participating in the "Rent A Practice For A Day" would be paid a lump sum for new Medicaid clients. A Memorandum of Understanding was completed for this strategy, in 2006, and no further action was taken due to Medicaid Dental Consultant position vacancy from September 2006 to April 2007.

The Basic Dental Emergency Form was updated to include the current codes and the fee schedule to include the minimum and maximum ages on the covered codes.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service |
|-------------------|---------------------------------|
|-------------------|---------------------------------|

| | DHC | ES | PBS | IB |
|---|-----|----|-----|----|
| 1. Pending the receipt of the Targeted State MCH Oral Health Service Systems Grant Program 2007 application, Montana continues to explore several new ideas to address dental access. | | X | | |
| 2. Medicaid attendance at the 2007 National Oral Health Conference to gain knowledge and participate in networking opportunities. | | | | X |
| 3. Ongoing participation as a member of the Montana Oral Health Alliance. Participation re-established in May 2007. | | | | X |
| 4. Continue ongoing collaboration with Montana Dental Association and the Oral Health Consultant | | | | X |
| 5. Pursue avenues to increase participation of dental providers in Medicaid. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Medicaid Dental Consultant position was vacant from September 2006 through April 2007 when Jan Paulsen began in this position.

The Covered Services Section of the Medicaid Dental Provider Manual continues to be updated.

The Basic Dental Emergency Form is being modified with the current CDT codes. The fee schedule was updated to include the new October 1, 2007 CDT 5 codes and the increased reimbursement rates.

<http://medicaidprovider.hhs.mt.gov/pdf/emergencydentalform0404.pdf>

Ongoing membership on the Montana Oral Health Alliance which includes participation in developing an Oral Health 5 Year Strategic Plan.

The DPHHS Oral Health Education Specialist and Medicaid Dental Consultant attended the 2007 National Oral Health Conference and gained a wealth of knowledge on the latest evidence-based best practice prevention strategies, and current oral health statistics. This information has been shared with the MT Oral Health Alliance, the Montana Dental Association, Community Health Centers, and the school fluoride mouth rinse coordinators.

The Medicaid Dental Consultant, Jan Paulsen, conducts personal meetings with individual and area provider groups regarding Medicaid concerns and program ideas.

c. Plan for the Coming Year

The Covered Services Section of the Medicaid Dental Provider Manual continues to be updated.

The Basic Dental Emergency Form will continue to be modified with current CDT codes.

HB 2 raised Medicaid provider rates to 85 percent of charges in the aggregate (currently pay 58 percent for adults and 64 percent for children). Additional funding is included to contract with community health centers and other providers to establish or expand dental services in the communities. The fee schedule was updated to include the new October 1, 2007 CDT 5 codes and the increased reimbursement rates. This information will be included on the Provider Notices

that are posted on the Web Portal which they all subscribe to as part of the claims system.

Montana will continue to explore evidence-based best practice solutions addressing the dental access issue.

Maintain its collaborations with Montana Dental Association, the Oral Health Consultant, Community Health Centers and providers to promote evidence-based best practice prevention programs aimed at children and pregnant mothers.

Montana Medicaid consultant and Oral Health Education Specialist plan to attend the 2008 National Oral Health Conference to gain knowledge and participate in networking opportunities.

Ongoing membership on the Montana Oral Health Alliance. This includes participation in developing an Oral Health 5 Year Strategic Plan.

The Medicaid dental consultant will continue to facilitate personal meetings with individual and area provider groups regarding Medicaid concerns and program ideas.

State Performance Measure 6: *Percent of pregnant women who abstain from cigarette smoking.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 81 | 81 | 82 | 83 | 81.6 |
| Annual Indicator | 80.3 | 80.5 | 80.6 | 81.0 | 80.6 |
| Numerator | 8746 | 9204 | 9308 | 9284 | 9980 |
| Denominator | 10886 | 11439 | 11554 | 11468 | 12388 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 81.6 | 81.7 | 81.7 | 81.8 | 81.8 |

Notes - 2006

Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of women who experienced a live birth in 2006 and reported not smoking during pregnancy, plus the number of women who experienced a fetal death in 2006 and reported not smoking during pregnancy. Denominator data includes all women who experienced a live birth or a fetal death in 2006. Vital records data on smoking in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence. This indicator was updated with final 2006 vital statistics data for the September submission. df

Notes - 2005

Numerator data for 2003, 2004, and 2005 was generated by Vital stats and includes both women who delivered a live birth and who experienced a fetal death and did not smoke during pregnancy. Denominator data included women experiencing a live birth or fetal death.

a. Last Year's Accomplishments

Montana contracted with 14 counties and 2 reservations to provide Public Health Home Visiting (PHHV) to at risk pregnant and/or women parenting an infant up to one year of age. In addition 6 Fetal Alcohol Spectrum Disorder (FASD) sites provided intensive case management services to pregnant women at very high risk for abusing alcohol, tobacco and other drugs (ATOD). Services included assisting with accessing quality health care early in pregnancy; family centered coordinated care, community resource referrals, advocacy, health education, and risk reduction.

In June, 2006 the FASD Support Specialist attended training on addiction and heard testimonials from women in substance abuse treatment.

The Child Adolescent, and Community Health (CACH) section was represented at each Quarterly Family and Community Health Bureau (FCHB) advisory council meeting.

State wide training was provided on the following screening tools: the American College of Obstetric and Gynecologist (ACOG) domestic violence, Tolerance-Annoyance Cut Down Eye Opener (T-ACE), the Edinburgh Postnatal Depression Scale (EPDS), and the Life Skills Progression (LSP). Contracted sites are required to report demographic data, outcomes of the screening tools, and make the appropriate referrals for the population they serve.

CACH facilitated monthly conference calls with FASD Support Specialists to provide support and technical assistance.

CACH collaborated with the Montana Tobacco Use Prevention Project (MTUPP) to target tobacco cessation education towards pregnant and parenting women.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. PHHV/Perinatal Nurse consultant will serve as a consultant to statewide advisory councils on smoking cessation. | | | X | |
| 2. PHHV/Perinatal Nurse consultant will act as a consultant for the PHHV and FASD prevention home visiting projects which promote smoking cessation. | | | | X |
| 3. Continue to fund 15 PHHV sites and 6 FASD sites | | | | X |
| 4. Collaborate with MTUPP to promote awareness of smoking cessation and cessation activities. | | | X | |
| 5. Coordinate with MTUPP and provide training to PHHV and FASD staff on smoking cessation among pregnant and parenting women. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

CACH and MTUPP are collaborating to provide training to PHHV and FASD staff on tobacco cessation, nicotine replacement therapy (NRT) options, medication, Medicaid coverage, and community resources.

The PHHV Nurse Consultant participated in a statewide assessment of the needs and resources for women involved in domestic violence.

CACH continues to contract with PHHV and FASD programs to provide services to high risk pregnant women and their infants up to one year of age. Contracted sites are using standardized screening tools for intimate partner violence (IPV), alcohol, tobacco and other drugs (ATOD) abuse, depression, and life skills. In addition, contracted sites are required to have a referral system for high risk pregnant women within their community. Technical assistance and follow up trainings are provided to all PHHV and FASD sites.

Attempts to recruit new PHHV and/or FASD sites through community outreach will continue.

Bi-monthly conference calls with FASD sites are held to provide support and technical assistance.

Completed annual training for FASD staff, and currently planning Fall 2007 PHHV staff training

CACH Section and PHHV contractors are working on development of a business plan which to collaboratively think through program activities, evaluate these activities to increase effectiveness and efficiency, and describe what information system is needed for program support

c. Plan for the Coming Year

Yearly FASD Advisory Council meetings and bimonthly FASD conference calls will continue.

The CACH section is collaborating with Montana's Tobacco Use Prevention Program (MTUPP) to provide a training on tobacco cessation for clients served by the PHHV and FASD programs

Funding through contractual agreements with counties and tribes will be used to provide PHHV and FASD Prevention activities and to promote smoking cessation in pregnant women.

Continued attempts to recruit new PHHV and/or FASD sites will be made through community outreach.

CACH will continue to participate in a statewide assessment with PHHV Program contractors to develop a business plan for the PHHV Program and the Maternal Child Health (MCH) Block Grant. The business plan requires CACH section and its contractors to collaboratively think through its program activities, evaluate these activities to increase effectiveness and efficiency, and describe what information system is needed for program support.

State Performance Measure 7: *Rate of firearm deaths among youth aged 5-19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 7.7 | 7.4 | 7.2 | 7 | 8 |
| Annual Indicator | 7.4 | 10.0 | 6.3 | 9.6 | 3.2 |
| Numerator | 15 | 19 | 12 | 18 | 6 |
| Denominator | 202571 | 189774 | 189830 | 187282 | 185491 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 8 | 8 | 8 | 8 | 8 |

Notes - 2006

Numerator is the number of deaths to Montana residents that occurred in Montana for youth ages 5 through 19 who were declared dead due to a firearm in 2006. Denominator data is census estimates of the number of youth aged 5 through 19 years in Montana in 2006. df

Notes - 2005

Numerator is the number of deaths to Montana residents that occurred in Montana for youth ages 5 through 19 who were declared dead due to a firearm in 2005. Denominator data is census estimates of the number of youth aged 5 through 19 years in Montana in 2005.

Please note that data were corrected with updated vital statistics and census data in 2007.

Notes - 2004

Denominator data was derived from Census estimates for Montana children ages 5 through 19 years of age in 2004. Numerator is the number of deaths for youth ages 5 through 19 who were declared dead due to a firearm. Please note that data were corrected with updated vital statistics and census data in 2007. The 2003 data should record 13 firearm deaths.

a. Last Year's Accomplishments

The State Fetal, Infant and Child Mortality Review (FICMR) coordinator produced a fact sheet and a press release on gun safety and storage based on Behavioral Risk Factor Surveillance Survey (BRFSS) data for distribution to the public.

The local FICMR teams expanded their capability to review children's deaths by including more counties and reservations in the FICMR reviews. The State and local teams continued to make recommendations for death prevention at the local level. Some local teams distributed gunlocks at local health fairs.

Efforts continued to recruit physicians into educating parents on safe gun use and storage safety in the home.

Funded 12 communities through the Garrett Lee Smith Suicide Prevention grant to implement local suicide prevention plans. Some of these plans included promotion of safe storage and usage of firearms.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Produce a press release at the beginning of the hunting season to promote awareness of safe firearm handling. | | | X | |
| 2. Provide at least two suicide prevention education and awareness workshops to emergency room and first responder professional staff, promoting means restriction relating to firearms. | | | X | |
| 3. The Youth Suicide Prevention Coordinator will coordinate with the State Fetal, Infant and Child Mortality Review (FICMR) Team's Biannual meetings to track firearm-related youth homicide and suicide completion rates and consider prevention strategies. | | | | X |
| 4. Provide technical assistance to 12 communities funded to implement suicide prevention activities. | | | | X |
| 5. The CNC/ FICMR coordinator will input firearm related death data from the local FICMR team case reports into Access Data base. | | | | X |
| 6. Continue to identify areas of preventability, through local FICMR team reviews, to direct public education, in firearm related deaths. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Montana's Child and Adolescent Health Coordinators work with the State's FICMR teams to gather data and identify possible strategies for promoting gun safety practices.

Gun safety and safe storage awareness are promoted via collaboration with local FICMR teams to disseminate firearm safety education materials to gun merchants and media in their communities.

The Child, Adolescent and Community Health (CACH) section is continuing its support for gun safety and awareness classes for youth provided by Fish Wildlife and Parks, 4-H, local public health departments and schools. Gun safety and safe storage of firearms is also routinely included in education provided during home visits to high-risk pregnant women and high-risk children. Suicide prevention programs make available firearm death prevention materials.

Collaboration with Healthy Child Care Montana and the Child Care Licensing Bureau to incorporate firearm safety in child care settings is also being explored.

Firearms are the leading means of suicide among the Montana's 15-19 year olds. The state's Youth and Young Adult Suicide Prevention Project funded 12 communities to implement suicide prevention activities at the local level, with some implementing means restriction efforts to include safe storage and use of firearms.

c. Plan for the Coming Year

CACH plans the following firearm-related activities for 2007:

Continue to promote awareness of gun safety practices through press releases to the public accentuating the practice of storing guns unloaded and locked and locking ammunition in a location away from guns.

Coordinate with the State FICMR team and BRFSS coordinator to monitor data on firearm deaths and identify prevention opportunities.

FICMR coordinator will coordinate a presentation on use of gun locks and educational information to all local FICMR coordinators at the Fall meeting.

Collaborate with State Injury Prevention Coordinator to inform the public on gun safety via state EMS/Trauma webpage. The webpage includes state statistics, prevention tips for kids, adults, parents, locations to get free or low-cost trigger locks, and links to downloadable games for teachers.

Continue support for gun safety and awareness classes for youth provided by Fish Wildlife and Parks, 4-H, local public health departments and schools.

Continue to support educational efforts toward gun safety and safe storage of firearms that is provided during home visits to high-risk pregnant women and high-risk children.

Coordinate efforts with the Statewide Youth and Young Adult Suicide Prevention Project to promote awareness of proper and safe storage of firearms through production of brochures and promotion of means restriction trainings.

State Performance Measure 8: *Percent of low birth weight infants among all live births.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | 6 |
| Annual Indicator | | 6.7 | 7.7 | 6.6 | 7.2 |
| Numerator | | 767 | 881 | 757 | 891 |
| Denominator | | 11384 | 11514 | 11414 | 12339 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 6 | 6 | 6 | 6 | 6 |

Notes - 2006

The Montana Office of Vital Statistics is the data source for this performance measure. The numerator includes low birth weight births to Montana residents that occurred in Montana. The denominator includes the number of births to Montana residents that occurred in Montana. The data for this indicator were updated with final vital statistics data for the September submission.

Notes - 2005

Birth records for Montana residents born outside of the state are not included in this number.

a. Last Year's Accomplishments

Discussions with the Indian Health Service MCH Nurse Consultant and contractual arrangements with tribes for Public Health Home Visiting (PHHV) activities and Fetal Alcohol Spectrum Disorder (FASD) prevention continued to strengthen state and tribal efforts to prevent prematurity and low birth weight.

Methamphetamine use and its effects on the fetus and pregnancy was the topic of the Montana Perinatal Association conference in April 2006 which was attended by PHHV staff from around the state.

CACH section contracted with 14 counties and 2 reservations for Public Health Home Visiting (PHHV) to at risk pregnant and/or women parenting an infant less than one year old. In addition 6 FASD sites were contracted with to provide intensive case management services to pregnant women at very high risk for abusing alcohol, tobacco and other drugs (ATOD). Services included assisting with accessing quality health care early in pregnancy, family centered coordinated care, community resource referrals, advocacy, health education, and risk reduction.

A new Public Health Home Visiting/Prenatal Substance Abuse Nurse Consultant was hired to coordinate the PHHV and FASD Programs. A new Child Health Nurse Consultant (CHNC) began in June 2006 to coordinate state Fetal Infant Child Mortality Review (FICMR) activities, school health activities and child health outreach and education. Both of these positions had been vacant for several months.

Information reported in the third Fetal Infant Child Mortality Review (FICMR) report was distributed to stakeholders across the state, including legislators, during the 2007 legislative session.

Smoking and pregnancy information was given to FICMR coordinators and educational materials for Public Health (PH) offices were made available to order.

A presentation was given to FICMR coordinators in October, 2006 about the new methamphetamine addiction treatment facility for women in Boulder, Montana.

Biannual FICMR coordinators meetings were held to share and discuss information about premature birth prevention. Some of the communities provided information about how to help pregnant women meet and keep prenatal appointments.

Published the third FICMR report, which addressed prematurity and low birth weight risk factors by September 30, 2006.

Disseminate the information in the third FICMR report to stakeholders across the state including legislators during the 2007 legislative session.

Prematurity prevention outreach was provided to FICMR coordinators, PHHV sites, and FASD Prevention networks to keep them up-to-date on prevention opportunities and approaches.

The most recent March of Dimes Prematurity Prevention materials were distributed to the FICMR team members, coordinators, and PHHV and FASD sites. CACH staff also assisted with their "Walk America Prematurity Prevention" campaign by educating our partners and raising public interest in and support for prematurity prevention.

Training was provided to FASD support specialists on the signs and symptoms of premature labor.

The CHNC participated in several cross-cutting committees related to child health and risk factors for low birth weight. In 2006 she participated on the Drug Endangered Children Task Force, which held discussions on the effects of prenatal drug exposure and how to take advantage of opportunities to address the issue. The CHNC also took part in the Children's Environmental Health Committee, which discussed prenatal exposures to environmental contaminants.

At the Spring Public Health Conference, the CHNC facilitated a presentation on Drug Endangered Children. She also participated in the Florida Area Health Education Center (AHEC) Network teleconference on Helping Pregnant Women Quit Smoking.

CACH Section promoted prematurity prevention as a component of Medicaid's Targeted Case Management (TCM) program, which provides assessment, monitoring and referral of clients.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue collection and review of Fetal, Infant, and Child Mortality Review (FICMR) and Public Health Home Visiting (PHHV) data related to low birthweight. | | | | X |
| 2. Promote good prenatal care and prevention of preterm birth through PHHV and intensive case management by support specialists in the Fetal Alcohol Spectrum Disorder (FASD) prevention projects. | | | X | |
| 3. Promote good prenatal care and prevention of low birthweight infants through the work of the FICMR state team and FICMR coordinators. | | | | X |
| 4. The PHHV/FASD Nurse Consultant will continue to provide education and training to the public health home visitors and FASD support specialists on prevention of low birth weight. | | | | X |
| 5. Continue to provide funds to PHHV sites and FASD prevention sites to collect data related to low birth weight | | | | X |
| 6. FICMR Coordinator will continue to distribute informational materials about smoking and pregnancy risk to local FICMR coordinators | | | | X |
| 7. | | | | |
| 8. | | | | |

| | | | | |
|-----|--|--|--|--|
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The year end evaluation report for the FASD program was completed in January, 2007 and submitted to the grantee.

The FASD Support Specialist annual training was completed in April 2007. This training included facilitating change through motivational interviewing.

CACH conducted community and agency outreach to promote the PHHV and FASD program, as well as recruit new sites.

Contracting continued with PHHV and FASD programs to provide services to high risk pregnant women and their infants up to one year of age. Contracted sites are using standardized screening tools for intimate partner violence (IPV), alcohol, tobacco and other drugs (ATOD), depression, and life skills. In addition, contracted sites are required to have an established system for receiving referrals for high risk pregnant women within their community. Technical assistance and follow up trainings were provided to all PHHV and FASD sites.

Collaboration continued with Montana Tobacco Use Prevention Program (MTUPP) to facilitate training for tobacco cessation for the PHHV and FASD population.

CACH continued their partnership with the March of Dimes Prematurity Prevention Campaign.

Collaborative efforts between the PHHV/Perinatal Substance Abuse Nurse Consultant and CACH to distribute materials on prematurity prevention to the local FICMR coordinators and Public Health Departments also continued.

c. Plan for the Coming Year

CACH will continue their contractual arrangement with counties and tribes to provide PHHV and FASD prevention services and will respond to the Substance Abuse and Mental health Service Administration (SAMSHA) request for proposal (RFP) for continuation funding for the FASD program.

A yearly meeting of the FASD Advisory Council, and twice yearly meetings of the FICMR coordinators and statewide FICMR team will be held.

Up to date materials on Prematurity prevention and smoking cessation will be provided to FICMR coordinators as it becomes available.

The standardized FICMR data collection will be used at the local level to collect data and finalize it in order to prepare a planned 2008 report

CACH plans to collaborate with WIC to provide educational materials on positive health behaviors promoting a full term delivery.

Continue to utilize and disseminate March of Dimes Prematurity Prevention materials, including Kicks Count and Motion Matters, to FICMR coordinators, PHHV sites, and FASD prevention networks, and through advisory council meetings

PHHV, FASD, and FICMR programs will receive ongoing technical assistance and support for the.

CACH will contact the National Director of NFIMR for technical assistance on up to date informational materials to prevent prematurity risk factors in pregnant population.

Telephone conferences with perinatologists and neonatologists from around the state will be held to coordinate prematurity prevention education.

State Performance Measure 9: *Percent of Montana public middle and secondary schools that include comprehensive sexuality education as part of their health curriculum.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2002 | 2003 | 2004 | 2005 | 2006 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | 62.6 |
| Numerator | | | | | 107 |
| Denominator | | | | | 171 |
| Is the Data Provisional or Final? | | | | | Final |
| | 2007 | 2008 | 2009 | 2010 | 2011 |
| Annual Performance Objective | 63 | 70 | 70 | 70 | 70 |

Notes - 2006

New SPM for the MCH BG 08 Application. The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey included only high schools, therefore middle schools are not included in this first year of data reporting, although the intent is to include them in future surveys. 20 (11.7%) of the 171 high schools did not respond to the survey.

The data used for this indicator suggest that 25% of the schools reporting comprehensive sexuality education as a part of their curriculum actually only teach about contraceptive failure rates. The definition of comprehensive sexuality education used for this performance measure will be reviewed over the coming year. As a result, schools that only teach about contraceptive failure rates may not be included in the numerator in the future, which would result in a lower indicator. ahb df

a. Last Year's Accomplishments

This is a new performance measure for the 2008 MCHBG application.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|---------------------------------|-----------|------------|-----------|
| | DHC | ES | PBS | IB |
| 1. WMHS will collaborate with MT Partnership for Sexuality Education to expand access to comprehensive sexuality education in public middle and secondary schools | | | | X |
| 2. WMHS will assist with data collection related to the number of MT schools (middle and secondary) providing mandatory comprehensive sexuality education for evaluation purposes | | | X | |
| 3. WMHS will provide technical assistance to family planning delegate agencies in order to expand their outreach services to local schools | | X | | |
| 4. | | | | |
| 5. | | | | |

| | | | | |
|-----|--|--|--|--|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

This is a new performance measure for the 2008 MCHBG application.

c. Plan for the Coming Year

WMHS will collaborate with Montana Partnership for Sexuality Education, family planning delegate agencies, and the Joint Coalition for Healthy Kids to expand access to comprehensive sexuality education in Montana public middle and secondary schools from 71% (2003, secondary schools only) to 80% (2010, middle and secondary schools). As requested, WMHS will send a delegate to Montana Partnership for Sexuality Education meetings to provide technical assistance on sexuality education curriculum guidance and state data. By June 2008, WMHS will assist with data collection related to the number of public middle schools in Montana providing mandatory comprehensive sexuality education for evaluation purposes. Currently, base figures exist for Montana public secondary schools, but no comprehensive evaluation has yet been conducted for Montana public middle schools. Survey results will be available by January 2009. Information will be shared with family planning delegate agencies in order to broaden the coalition's efforts. Apart from providing technical assistance to the Montana Partnership for Sexuality Education, WMHS provides technical assistance to 12 family planning delegate agencies, representing 27 Montana communities. Regular technical assistance will continue to be given related to community outreach and education on sexual health. WMHS will continue to provide technical assistance to family planning delegate agencies in order to expand their outreach services to local schools, especially as the need for sexuality educators increases. Additionally, WMHS will continue to participate in the Joint Coalition for Healthy Kids (JCHK), providing a forum for collaboration between DPHHS and OPI. WMHS staff will present the new performance measure to JCHK, provide regular updates on progress, and collaborate with OPI staff as needed.

E. Health Status Indicators

The Health Status Indicators (HSIs) are a useful source of multi-year data on the measures. Montana's relatively small population can result in a low number of cases for some outcomes, particularly for uncommon health events. Alternatively, an increase or decrease of one or two cases from one year to the next can result in the appearance of drastic increases or decreases in the rates of some outcomes. Major increases in the frequency of a particular event from one year to the next do not necessarily demonstrate a significant increase, and while small numbers of events or outcomes present particular opportunities and challenges in analysis, they are not necessarily an indication of a lack of need. Therefore, annual frequencies, rates or calculations may vary widely and be less descriptive than the multi-year perspective captured in the HSIs.

Collecting the health status indicators in one location, at one time is a useful overview on Montana's residents. The data reported in the HSIs are used often in grant applications, reports and programmatic activities, but they are often only on more specific topics. For example, data on motor vehicle crashes and sexually-transmitted diseases are discussed and used within those programs, but rarely are data on such programmatically disparate topics brought together and used to create a broader perspective of the health status of the state's population.

Some health status indicators are more useful than others in serving as surveillance and

monitoring tools or acting as evaluative measures. Montana encounters challenges in reporting on some of the health status indicators, specifically those for which something other than vital records is the expected data source. Those health status indicators are less helpful information on the state's residents, although some of them provide a data collection goal to strive for.

For those health status indicators that Montana does not have an ongoing, stable source of data for, such as the rate of nonfatal injuries among children (HSI04A), investigating possible data sources can result in new connections with programs outside of the state Title V program and increased knowledge within the Title V program of activities elsewhere in the health department. While this is useful programmatically, it does often mean that the indicator itself is not comparable from year to year and does not offer an accurate perspective on the health status being measured.

Some information collected in the HSIs may be more useful in directing public health efforts with additional narrative information to provide perspective or background on the measure. For instance, in the 2007 MCH Block Grant Application, Montana has added low birth weight as a new state performance measure. Although birth weight under 2,500 grams is already captured in Health Status Indicator 01A, prevention of low birth weight and premature birth are priorities of the Family and Community Health Bureau (FCHB), and the narrative section of the performance measures allows the state to track the data as well as related initiatives, programs and interventions.

F. Other Program Activities

Although mentioned elsewhere in this document, the importance of continuing to develop and refine the public health system and its capacity to support the delivery of the core functions and essential services of public health is worth emphasizing. Due to the rural/frontier nature of much of the state, we depend upon a public health workforce that is overburdened and under funded. In order to maximize the health of the public, and specifically the health of the MCH population, it is important that state level efforts continue to focus on supporting linkages and encouraging efficient delivery of services. A focus on population-based services is also key, with MCH continuing to struggle with its perceived role as a safety net provider of services otherwise not available or funded. The efforts of the Public Health Improvement Bureau and the public health informatics section will continue to help educate and support the workforce, and to improve and streamline reporting in order to decrease the burden on local contractors.

Reviewer questions asked for an examination of the low birth weight (LBW) incidence in Montana. A review of the existing data revealed that there appears to be a trend in the incidence of LBW births in Montana. Low birth weight, defined as births less than 2500 grams, is a standard indicator of perinatal health at both the state and federal levels. In response to this concern, a low birth weight trend analysis was performed on aggregate state data for the years 1995 to 2004, stratified by year and race. Using the Cochran-Armitage test for trend for the years in question regardless of race, there appeared to be a significant positive linear trend for the occurrence of low birth weight events in the state. Further investigation into the trend revealed that Native American populations were 16% more likely to have a low birth weight baby than Caucasian populations, however, they were not the cause of the positive linear trend, with noticeable highs and lows apparent for multiple years. The Caucasian population's variability over time was the significant cause of the positive linear trend seen in the analysis, rising approximately 30% since 1995.

In addition, strategic planning will be a focus during the remainder of 2005 and 2006. Further prioritization of health needs will occur using the priorities identified by stakeholders throughout the state and the involvement of FCHB Advisory Council Members and staff.

/2008/ The FCHB five sections continued their work on developing their respective work

plans which in turn have been incorporated into the Bureau's strategic plan which is attached to this application. The Montana Oral Health Alliance resumed their meetings and completed Montana's Oral Health 5 Year Strategic Plan which formed the basis for the Targeted State MCH Oral Health Service Systems Grant Program 2007 application. The Oral Health Alliance will continue to meet and refine the Strategic Plan this coming year.

The FCHB Advisory Council continued to be involved with identifying priorities. As noted elsewhere, the Governor's Office has replaced the FCHB Advisory Council with the Family Health Committee, with Governor Appointments expected to be made in the Fall of 2007

A portion of the State Systems Development Initiative (SSDI) grant supported an assessment of the Public Health and Safety Division's information systems and data reporting requirements, which includes Maternal Child Health (MCH) data collection. This assessment was completed by Pete Kitch of KIPHS Inc. and the recommendation is that the Bureau uses the Business Process Analysis (BPA) to analyze how MCH currently works with their stakeholders (i.e. local health department officials). This process will include examining how work is currently being completed and "rethinking" on how things should work in determining the information needed to meet federal grant requirements. A committee, consisting of Bureau members and stakeholders will use this methodology as a way to determine the best solution for selecting a proper information system. It is anticipated that completing the BPA will help increase the state's and local's data collection capacity and decrease the burden on local contractors. SSDI funding will also be used to improve and develop data collection and analysis systems for MCH data based on the BPA recommendations. //2008//

G. Technical Assistance

Technical assistance needs identified to date include:

1. A second FCHB Epidemiologist is anticipated to begin on September 1, 2007. The FCHB has identified the need for assistance with reviewing and identifying the Epidemiology Unit's capacity and activities addressing the 2009 Fiscal Year needs. Identifying the Epi Unit's current capacity and ability to meet the FCHB epi's needs will also be useful for the FCHB's planning process the 2010 Needs Assessment. Consultant Roger Rochat, MD, a professor at Emory University and former GA and CDC epidemiologist, has been identified as the trainer.

2. The Family and Community Health Bureau has identified the need for technical assistance for developing the foundational work for the 2010 MCHBG Needs Assessment. The Needs Assessment is a critical tool for adequately assessing the current and future public health care needs for our state. An Emory University student(s) are being requested and with the technical assistance dollars, the student would be assigned to conduct an in-depth EPI analysis based on the work completed by Roger Rochat. (see TA #1)

3. Women and Men's Health reported that almost one-third of their SFY 07 clients were teenagers and outreach is conducted to teens because they are considered at high risk for pregnancy and birth. The WIC and CACH also work with teenagers. The FCHB has identified the need for training on the teen brain research that illuminates the source of teen behavior: their developing prefrontal cortex of a teen brain, which is responsible for impulse control, future thinking, logic, and reason. Andrew Robinson, M.Ed. has been identified as a trainer.

V. Budget Narrative

A. Expenditures

Montana depends upon its local partners for provision of MCH services to the population. 42% of the MCHBG is distributed to local county contractors under MCH services contract. Local match continues to be well beyond the required level, with local match of about \$3.6 million, instead of the approximately \$825,000 which would be required under the present contract. Montana does not have enough state general fund to pull down the federal funding, with a total of slightly over \$1 million, instead of the \$1.9 million needed.

Local match continues to increase, partly due to improved reporting expectations and compliance, and due to the response of locals to the request for accurate reporting which will allow better understanding of true costs of MCH services. For the first time in 2004, we were able to capture and report the program income.

Please see attachment for charts depicting trends.

Form 3 - Federal funding stayed about the same from 2001 through 2004 - federal decreases in 2005 and potentially 2006 will result in a drop in the federal level. The state funding also continues to go down slightly. Efforts to increase funding are anticipated for the 2007 session, depending upon fiscal picture. Local funding has had the most increase, albeit variable.

Form 4 - Children continue to be the primary target of services in the state. Screening programs, including school health services would be included in those costs. Many county health departments continue to assume school health services as part of their responsibilities, often without funding from the school district or reimbursement from insurance coverage's. The increase in infant and pregnant women expenditures may be in part attributed to the program income, much of which is for targeted case management for high risk pregnant women and infants. Variations between budgeted and expended amounts continue to vary by as much as 40% in some categories (pregnant women and others).

Form 5 - Direct expenditures reported by the counties continue to be high. This is in part due to definition and reporting issues. Large variations in expenditures by level of the pyramid continue. While definition issues continue to confound, a large percent of funding continues to support direct health care.

/2007/ Montana continues to experience decreases in MCHBG funding due to federal decreases and population shifts. Montana's block grant allocation has decreased by over \$180,000 since 2001. County contracts, accounting for approximately 42% of the overall budget have decreased, as have state level program budgets. Cost allocation, or administrative costs, have increased. Counties have continued to overmatch the MCHBG, providing far more match than is required by contract.

Form 4 - Children's services continue to account for the largest portion of the federal/state/local MCH partnership. Counties commit over \$2 million annually to services for children aged 1 - 22. Children with special health care needs have also received more resources from counties over the last year.//2007//

/2008/

Montana's block grant allocation was decreased in FFY 06 by \$85,000. For FY 08, the federal funding is estimated to remain the same as for FFY 06 and 07, \$2,462,222. The county contracts continue to reflect approximately 42% of the total budget. The cost allocation or administrative costs increased, but are within the 10% threshold. Children's services continue to receive the greatest portion of the federal/state/local MCH

B. Budget

The proposed budget for FFY 2006 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children \$ 1,008,269

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs \$829,709
Primary and Preventive Services for Children \$ 1,008,269

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs \$829,709

Budget includes the CSHS budget of \$764,000 plus \$65,000 of county MCHBG which they report expending on the CSHCN population.

Title V Administrative Costs \$224,404

Includes state indirects of \$176,633 plus anticipated local of \$47,777. Administrative rule allows counties to use up to 10% of their award for administrative costs. The state admin costs are increased by approximately \$40,000, due in part to conversion of the BC position for "direct pay" to cost allocation.

Unobligated balance \$0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds \$1,085,637

Budget includes public health home visiting general funds (\$550,000) and funds to support the voluntary genetics program (approximately \$530,00).

Local MCH Funds \$3,598,977

Local contractors continue to overmatch their contracted \$1.1 million.

Program Income \$791,235

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Contractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership \$8,023,781

Other Federal Funds \$18,334,262

/2007/

The proposed budget for FFY 2007 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children \$ 955,473

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families. Decreased from last year due to decreased federal funding available.

Children with special health care needs \$838,666

Slightly increased from last year due to county efforts.

Title V Administrative Costs \$194,083

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance \$0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds \$1,440,467

Budget includes public health home visiting general funds (\$550,000), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately \$850,000).

Local MCH Funds \$3,165,000

Local contractors continue to overmatch their contracted receipts.

Program Income \$743,094

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Contractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership \$7,810,783

Other Federal Funds \$19,458,492

Tables depicting the changes in Montana's Title V funding are attached. //2007//

/2008/

The proposed budget for FFY 2008 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children \$ 873,000

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and

others, including families.

Children with special health care needs \$838,666

Title V Administrative Costs \$212,658

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance \$0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds \$2,173,902

Budget includes public health home visiting general funds (\$550,013), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately \$1,045,000 per 2007 Legislative action).

Local MCH Funds \$3,500,746

Local contractors continue to overmatch their contracted receipts.

Program Income \$914,508

Program Income shows an increase due to CSHS' clinic billing. Also county contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Contractor imposes any charges for services under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership \$9,051,378

Other Federal Funds \$19,104,399

//2008//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.